ABSTRACT

Title of Thesis:	DEPRESSION AND PERCEPTION OF FAMILY COHESION LEVELS AND SOCIAL SUPPORT FROM FRIENDS IN EMERGING ADULTHOOD AT A UNIVERSITY MENTAL HEALTH CLINIC
	Sabrina Roc, Master of Science, 2020
Thesis Directed By:	Dr. Patricia Barros, Department of Family Science

Emerging adulthood is identified as a period of transition and uncertainty that occurs between the stages of adolescence and adulthood, often from ages 18-25. During this period, mental health issues are quite prominent, especially symptoms of depression. Previous research has explored what can ease the stress of depressive symptoms, and social support has had resounding effects. The present study used a secondary analysis of data from 372 therapy-seeking individuals at a university-based family clinic to evaluate how perceived levels of familial cohesion and social support from friends are associated with depressive symptoms during emerging adulthood and whether or not age moderated the association. The results of this study show significant associations between familial cohesion as predicted, and social support from friends but in unexpected direction. Age did not appear to have any significant associations. Potential future research as well as clinical implications are discussed.

DEPRESSION AND PERCEPTION OF FAMILY COHESION LEVELS AND SOCIAL SUPPORT FROM FRIENDS IN EMERGING ADULTHOOD AT A UNIVERSITY MENTAL HEALTH CLINIC

by

Sabrina Roc

Thesis submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Master of Science
2020

Advisory Committee:
Dr. Patricia Barros, Chair
Dr. Ghaffar Ali Hurtado Choque
Dr. Mona Mittal

Acknowledgements

I tend to think in “worst-case scenarios,” and in the process of writing this thesis I have created “massive, catastrophic scenarios.” But in the midst of it all, I have been blessed with amazing support and constant reassurance that things will turn out well, and continuously helped me create “best-case scenarios.”

Patricia, you have been a phenomenal thesis advisor. I am so appreciative that you agreed to take this journey with me. I have received nothing but support from you, especially when the pandemic added another layer of difficulty. You have given me your time, precious and valuable that it is. You challenged me to think critically and push myself beyond what I thought I could handle. Thank you so much for standing by my side and cheering me on.

Mona and Ali, thank you for agreeing to be members of my committee. Thank you for being flexible when the world changed and continuing to make yourselves available to me. You both have provided me with important insight and feedback, and I truly have enjoyed working with you.

Special shout-out to my cohort: the only six people that fully understand the depths of what we have accomplished. Jen and Toyosi (CC), in the midst of all the stress and sheer craziness of this program you have made two-plus years better than I could have imagined. I am so grateful to call you friends. Know that I am standing and shouting in your corners just as much and as loud as you both have been in mine.

To my amazing friends and family, thank you for loving me and giving me the green light to be M.I.A. in group chats, late to reply to texts, miss all the phone calls, and say no to spontaneous plans for the past two years. You have no idea how much it has meant for me to be able to pursue this dream with your love and encouragement. You have been the best safety net—always ready to catch me through it all.

Table of Contents

List of Tables

Chapter 1: Introduction

Statement of the Problem

Significant research indicates that existing adolescent individuals have yet to fully mature and complete certain milestones by the age of 18 to be considered "adults" (Arnett, 2000; Bonnie et al., 2014; Reifman et al., 2007; Scales et al., 2016), therefore, Jeffrey Arnett (Arnett 2000, 2019; Arnett & Fisher, 2014; Arnett & Tanner, 2006) proposes a separate developmental stage to be defined as emerging adulthood or transition to adulthood. There are several key elements attributed to this separate stage of development, such as the completion of overall brain development, learning about the nuances of intimacy and mutual support, intensification of pre-existing friendships, and family-oriented socialization (Konner, 2019). Considering the complexity of this stage, Benson and colleagues (2004) propose that a healthy interplay among eight specific dimensions herald a successful transition to adulthood: physical health, psychological and emotional well-being, life skills (including financial independence), ethical behavior, healthy family and social relationships, educational attainment, constructive engagement, and civic engagement. The present study focuses specifically on healthy family and social relationships, as well as psychological well-being and how they relate to one another in this phase of life.

Due to the high levels of personal uncertainty associated with this period of life, previous research has found an increased prevalence of mental health issues among young adults, particularly symptoms of anxiety and depression (Arnett &Tanner, 2006). Emerging adults have the highest rates of depression compared to any other age group

(Reed-Fitzke, 2019), and depression, suicidal thoughts, and mental distress appear to be on the rise (Hoyle et al., 2019), which corroborates the societal notion that maturing into adulthood is a complex and difficult stage of life. For those in this age group suffering from mental health issues, individuals typically experience an initial onset of symptoms of depression during their teenage years, reaching full criteria for major depressive disorder during the transition to adulthood (Mondi et al., 2017). Symptoms of depression are often thought to be linked to individuals' relationships (Santini et al., 2015), and further research is needed to investigate to what extent the quality of one's relationships with family and/or friends affects the level of depressive symptoms among young adults, especially if these associations vary depending on the particular age of the individual. This clarity is particularly important because if such associations can be made, clinical prevention and intervention work can be tailored toward enhancing relationship quality, both within the family system and among one's friend group, to avoid mental health crises.

During emerging adulthood, reliance on social support tends to increase and it becomes a fundamental aspect of personal adjustment (Pettit et al., 2011). Individuals in this stage of life are expected to leave the familial home and make important decisions about his or her education, career goals, and romantic partnerships (Arnett, 2000). Having sufficient family cohesion—a core family relationship quality component encompassing warmth, affection, closeness, and support within the family (Barber & Buehler, 1996; Barry & Fleming, 1990)—can impact whether one develops depressive symptoms during this transition period (Holt-Lunstad et al., 2010; Thoits, 2011), and one's chosen personal relationships, like friendships and romantic partner(s), can also

influence individual emerging adults in positive or negative ways (Schuster et al., 1990). Sufficient social resources (e.g., family, friends, social networks, etc.) can also help young adults navigate important milestones and bolster emotional well-being (Raffaelli, 2013). As such, establishing and maintaining social relationships have been proven to be important for successful future development (Hartup et al., 1999; Wrzus et al., 2012), and they provide one of the most fundamental sources of positive functioning and personal well-being for individuals. The distinction between specific support from family and friends has not been the focus of prominent research. Previous studies have looked at the overall components of social support (Pettit et al., 2011; Schulenberg & Zarret, 2006), but very few have looked at the intricacies of how support from family and friends could function as protective factors separately and therefore merits further exploration.

Research regarding support from family has been the focus of copious studies (Jenkins et al., 2013; Lane, 2015; Tam & Lim, 2009), but the exploration of social connectedness more specifically cohesion within the family as it relates to symptoms of depression during transition to adulthood has yet to be explored. Research has not explored the connection of closeness during the phase of emerging adulthood pushing the focus of this thesis to examine the association between family cohesion and depressive symptoms during this transition. Family is one source of social support; friendships are also pivotal and studying how support from friends and to support from family relate to depressive symptoms will be another focus of this study.

Another noteworthy component of this stage of life is that between the range of ages in emerging adulthood there is a re-negotiation of priority and importance in certain relationships (Arnett, 2016). Major contributions of depressive symptoms varies between

younger emerging adults (18-21) compared to older emerging adults (22-25). For younger emerging adults depressive symptoms are tied to post-secondary education adjustment (Al-Dabal et al., 2010; Collins & Mowbray, 2005; Heiligenstein & Guenther, 1996), and they rely heavily on support from their families (Atkinson & Lowe, 1995; Ciarrochi et al., 2003; Constantine & Arorash, 2001; Turner et al., 2007). Older emerging adults are transitioning from education into securing full-time employment and that process often contributes to their depressive symptoms (Creed,1999; Creed & Moore, 2006; Galambos et al., 2006). Studies have not explored and compared emerging adults by age to see the differences in what types of social support manage their depressive symptoms, but this study will explore that moderation.

The complexities of this phase of life can unfortunately make emerging adults susceptible to many mental health issues, and instead of focusing solely at the individual level (i.e., the one showing symptoms of depression), researchers and clinicians must look at the associations between the specificity of social support from family and friends and how they may affect the level of present depressive symptoms. Successful young adults have people they can turn to in times of need and that make them feel safe (Scales et al., 2016; Settersten & Ray, 2010) as they navigate and negotiate the difficulties of this maturation period. By better understanding the association between personal social support and the presence of depressive symptoms, we can better determine how successful one will be in the transition into adulthood and create interventions that will ensure success is continued throughout their adult lives.

Purpose

The purpose of this research is to add to the growing literature regarding Arnett's proposed developmental stage of emerging adulthood and to explore the associations between perceived social support from friends and family, specifically family cohesion, as they relate to depressive symptoms among young adults. This research also aims to investigate whether age moderated the association between levels of depressive symptoms and one's perception of levels family cohesion and social support from friends.

Research Questions

RQ1: How are perceived levels of social support from friends and family, specifically familial cohesion, associated to depressive symptoms during emerging adulthood?

RQ2: Does the relationship between perceived family cohesion levels and social support from friends differ due to the age of the emergent adult?

Chapter 2: Literature Review

Emerging Adulthood

The age period of 18–25 has been identified as an entirely new stage of development known as "transition to adulthood" or "emerging adulthood" (Arnett & Tanner, 2006). According to Arnett, this period is critical in setting oneself up for success in later adult life (Benson et al., 2004) due to the unique experiences that budding adults face—experiences often defined by new expectations, roles, and identities that one adopts during this stage (Scales et al., 2016). Once approaching emerging adulthood, youth are increasingly independent, acquire and manage higher responsibility, and take on an active role in their own well-being and development (Zarrett & Eccles, 2006). The key markers to a successful transition into adulthood have commonly been leaving the parental home for one's own residence, establishing financial independence, completing secondary and post-secondary education, gaining full-time employment, marriage, and becoming a parent (Scales et al., 2016).

Arnett (2000, 2006, 2014) proposed that the stage of emerging adulthood is characterized by five distinctive characteristics: identity exploration, feeling "in-between," self-focusing, enormous possibilities, and instability (Reifman et al., 2007). The "age of identity exploration" is when the individual discovers more about themselves. The second characteristic, "the age of feeling in-between," highlights the majority of individuals experiencing this stage who do not relate to his or her adolescent selves and feel ill-equipped to be adults. The "age of possibilities" is viewed as a positive and optimistic time for many emerging adults, and the "age of self-focus" empowers

individuals to explore their world while balancing their new sense of independence coupled with the added layer of new responsibilities. The fifth and final dimension is uncertainty, thus "the age of instability"—a period of defined by the unsettling and overwhelming nature of all the changes made, where individuals often feel insecure.

Eccles and Gootman (2002) identify several specific challenges within the developmental stage of emerging adulthood: the shifts in relationships with one's parents from dependency to an "adult" relationship, reflecting the emerging adult's increasing maturity and responsibilities in the family and the community; the exploration of new roles, both social and sexual; and the experience of more intimate partnerships and identity formation at both the social and personal levels. These coincide with Arnett's proposed characteristics of this stage, and the successful management of all these challenges depends on the social support available and the developmental settings in which young people can explore, interact, and experience these challenges.

Arnett (2014) highlights that there are cultural variations within this maturation process, and emerging adulthood is a time period that can vary amongst certain cultures and at certain ages in an individual's life. Extensive research has shown that there are different ways in which young people around the world negotiate this unique life stage between adolescence and adulthood (Raffaelli et al., 2013). It has been suggested that emerging adulthood as a stage of development is more likely to be experienced in countries that are highly industrialized or post-industrial (Arnett et al., 2014; Noble et al., 1996). Such countries require higher levels of education and training for entry into more stable, lucrative jobs, which can delay plans for marriage and parenthood as well as the identification of being an adult, both by the individual and by society. In

economically developed countries, the experience of emerging adulthood by individuals that live in urban cities differs from more rural areas, due in no small part to wealth disparity. For young people in developing countries, emerging adulthood exists only for the wealthier segment of society (Arnett, 2019). Saraswathi and Larson (2002) suggest that "in many ways, the lives of middle-class youth in India, South East Asia, and Europe have more in common with each other than they do with those of poor youth in their own countries." However, as globalization proceeds and economic development along with it, the proportion of young people who experience emerging adulthood will become more normative across different cultures and countries worldwide by the end of the twenty-first century (Arnett, 2000).

Internal negotiations are constantly being made within this stage as individuals manage the demands of familial and social responsibilities (Arnett et al., 2007; Horowitz and Bromnick, 2007). Given there are so many difficult aspects to navigate during the experience of transition to adulthood, it is paramount for researchers to explore how to help young adults manage these stressors effectively, particularly around the development and prevention of depressive symptoms.

Depressive Symptoms among Emerging Adults

Incidence and Prevalence. Depression (MDD) is a common mental disorder and appears to be steadily increasing worldwide: according to the World Health Organization (WHO), more than 264 million people are currently affected by it to various degrees. The National Institute of Mental Health (NIMH, 2019) reported in 2017 that 7% (17.3 million) of U.S. adults age 18 and older had at least one major depressive episode (MDE), with the highest prevalence of MDD among individuals ages 18–25 at 13%.

Depression often results from a complex interaction of social, psychological, and biological factors. Individuals who experience traumatic life events and major transitions are more susceptible to depression and depressive symptoms (World Health Organization, 2017). The Oregon Adolescent Depression Project conducted a longitudinal study (Rohde et al., 2013) looking at key characteristics of MDE throughout four developmental periods: childhood, adolescence, emerging adulthood, and adulthood. The rates of first incidence of MDD were highest in emerging adulthood (mean 18–23.9) at 24%. The study also focused on recurrences of MDD episodes in a developmental period other than the period where they experienced an initial instance; the findings yielded a 43% rate of recurrence in the emerging adulthood age bracket. The total cumulative depressive episode incidences indicates that emerging adulthood as a developmental period is often marked by this mental health issue.

In fact, most mental health disorders have initial onset during late adolescence and young adulthood (Paus et al., 2008): by the age of 25, 75% of individuals who will have a mental disorder have experienced their first onset (Kessler et al., 2007). Approximately 40% of young adults living at home have symptoms of or meet criteria for depressive disorder (Arnett and Fishel, 2014), and research suggests that one in four emerging adults will experience a depressive episode between the ages of 18–25 (Kuwabara et al. 2007). Given all the tasks to accomplish and hurdles to overcome during this stage of development, it is understandable that young adults may be at risk for developing mental health symptoms, especially due to personal failures or difficulty in achieving social expectations of adult life (Kaplan et al., 1983).

Risk and Protective Factors. The high prevalence of depression during the transitional period of emerging adulthood have led researchers to look into specific risk factors that contribute to symptoms as well as protective factors that mitigate symptoms (Kaman et al., 2020; Masten, 2009; Willie and Ravens-Sieberer, 2010). Studies have found that cumulative adverse experiences, negative coping strategies (Breton et al., 2015), parental mental health (Klasen et al., 2015), conflicts with parents (Bradford er al., 2017), and problematic relationships (Voncina et al., 2018) can all be predictive factors of depressive symptoms in emerging adults.

Frye and Liem (2011) completed a four-year longitudinal study to investigate the diverse patterns of depressive symptoms among emerging adults. The sample included 1,143 18–22 emerging adults from nine schools throughout the Boston metropolitan area, and the researchers focused on measures considered to be risk factors for depressive symptoms (e.g., family poverty status, SES, trauma history, and race and ethnicity). The data supported four distinctive groups of those experiencing depressive symptoms in emerging adulthood: one large group with low, stable rates of depression; a smaller group with initially higher levels of depression followed by a sudden decline over four years; a group which began with moderate levels that sharply increased over time; and a small group with very high, stable rates of depressive symptoms. The researchers proposed that their sample was more than likely a normative group composed of largely well-adjusted young people who continue to have low levels of depressive symptoms. The 8% of the sample that did suggest depressive symptoms were an actual issue allowed for the researchers to work through several theories on how this will implicate clinical practice

moving forward and add to the growing literature concerning this period of immense developmental change in emerging adults.

Hungarian researchers (Lisznyai et al., 2014) aimed to identify the risk factors and background variables of depression in order to try to profile which students would seek help at a campus's counseling center. Using the Beck Depression Inventory (BDI), Lisznyai and colleagues sent online questionnaires to 773 student participants at Corvinus University in Budapest to measure whether "social capital" (relationship status and sexual life, quality of relationships, and involvement in campus activities), life skills, occupational identity, bullying victimization, and substance abuse could predict risk of depressive symptoms. Both financial status and life skills were determined to be contributors to depressive symptom development. The findings also yielded that key factors of social environment (friendships and university atmosphere) are critical to tempering potential depressive symptoms—factors of particular relevance to the current study.

Protective factors influence the processes by interrupting the pathways through which risk factors often operate (Coie et al., 1993) and diminishing the effect of specific stressors and risk factors (Shortt and Spence, 2006). Familial resources, positive parenting (Raya Trenas et al., 2020), family cohesion (Sze et al., 2013), social support (Monahan et al., 2014), personal competence (Moksnes and Lazarewicz, 2019) and optimism (Brenton et al., 2015) have had beneficial effects on managing depressive symptoms. A Canadian study (Colman et al., 2014) focused on examining the potential protective factors of depressive symptoms during adolescence against the onset or recurrence of depression in early adulthood. The study longitudinally followed 1137

members of Canada's National Population Health Survey from ages 12-17 between 1994 and 1995 and then contacted them every two years until 2009. Researchers measured for depression status and several adolescent protective factors (sense of mastery, social support, physical activity, self-esteem and education). Their findings indicated that the negative effects of stress on depression were alleviated by increased physical activity, higher overall education level, and social support. Participants with high social support in adolescence were significantly less likely to become depressed compared to those with low social support- key components to the current study.

As previous research has shown, depressive symptoms are common during the transition to adulthood due to the series of developmental challenges associated with this period of development. The growing occurrences of depressive symptoms can have many consequences to overall successful adult outcomes. Certain factors can influence the development of depressive symptoms and increase the probability of negative health outcomes, while protective factors support positive development. The present study makes an effort to speak on these connections and offer insight into how social support can be related to more debilitating symptoms.

Social Support

A byproduct of the exploratory nature of emerging adulthood is the reconfiguring of relationships, especially close ones (Arnett, 2006). Social support at its core is defined as having friends and family to turn to in times of crisis. Having this support allows individuals a broader sense of identity and the ability to focus on personal issues. A 2010 study conducted by Holt-Lunstad and colleagues involved a systemic review and meta-analysis of relevant literature to determine the quality and quantity of individuals' social

relationships as links to mental health, morbidity, and mortality. Across the 148 studies they reviewed, it was clear overall that an individual's social relationships can affect their health; more specifically, evidence was found that good relationships can prolong life expectancy and poor social relationships can potentially be more harmful than excessive drinking, smoking, obesity, and lack of exercise (Holt-Lunstad et al., 2010).

Considerable research has explored the relationship between social support and depressive symptoms (e.g., Holt-Lunstad et al., 2015; Oxman et al., 1992; Thoits, 2011). As social creatures, interpersonal relationships are among a human being's most fundamental sources of positive functioning and well-being. Consistent with earlier reports, Schuster and colleagues (1990) found that negative interactions are as significant as or, in some cases, more significant than supportive interactions for their effect on depressed mood. These results support the argument that the absence of negative social interactions is as important as social support for positive emotional functioning. There is also significant literature that looks at the association between social support and depressive symptoms among adolescents and emerging adults—social support being comprised of friendship and familial support (Dingfelder et al, 2010; Lee & Dik, 2016), but this research will focus on the distinction between these two support systems. The role and effect of social support on health and psychological well-being varies depending on the source of that support (Li et al., 2014; Walen & Lachman, 2000). A large scale, systemic review of the association between social relationships and depression was conducted by Santini and colleagues (2015). In their systematic review of 51 studies, the researchers focused on investigating the association between either of the three major domains of social relationships (social support, social networks, and social

connectedness) and depression in adults; any published studies exclusively on infants, children, and adolescents were excluded. Social networks are the formal structure of social relationships based on size, composition, contact frequency and boundaries (Prince et al., 1997), and social connectedness refers to the extent in which an individual feels a sense of belongingness, togetherness, or relatedness within their relationships (Townsend and McWhirter, 2005; Williams and Galliher, 2006) The review confirmed that perceived social support and large social networks play protective roles against depression. The strongest and most consistent findings amongst the studies were the significant protective effects of perceived emotional support, perceived instrumental support, and diverse social networks. However, little was found on the level of social connectedness to depressive symptoms, possibly due to those measures not being commonly utilized in the studies reviewed. The present study aimed to focus on social connectedness and its association with depressive symptoms in order to fill this gap in the literature, because people in relationships where they feel a sense of belonging and connection can function as a protective factor against on mental health issues. A 2011 longitudinal study by Pettit and colleagues examined the trajectories of depressive symptoms and perceived social support among 816 emerging adults in a sample drawn from the Oregon Adolescent Depression Project (OADP). The study found that among emerging adults greater experiences of perceived social support were associated with lower depressive symptoms. Perceived support from family was significantly negatively associated with depressive symptoms in women and positively associated with depressive symptoms in men.

Familial and friend support often relate to depressive symptoms differently and for a multitude of reasons. First and foremost, a person's family is not chosen like friends

usually are (Collins & van Dulmen, 2006), so the interpersonal interactions are different, and the interactions between the different kinds of support affect individuals differently. For some people, family members can be psychologically closer to the individual than friends (Antonucci, 1994) and may therefore have a greater impact on one's well-being. It has been suggested that relationships with family and friends may serve different functions, with friends primarily satisfying needs for social integration and self-worth and family primarily satisfying needs for intimacy and emotional support (Barry et al., 2009; Furman & Buhrmester, 1992). Certain aspects of emerging adulthood, such as the formation of new families through marriage and children as well as the movement back and forth between dependency on and independence from one's family of origin, suggest that social support from family and social support from friends may differ throughout this stage of transition and fulfill separate needs.

Although previous research has emphasized the importance of social support to the overall well-being at the individual level (Lane and Fink, 2015; Taylor et al., 2014), there is not much research distinguishing social support received from family separately from social support received from friends as it relates to symptoms of depression, particularly during the transition into adulthood. The present study specifically makes that distinction, as the quality and differences between these relationships are essential for adjustment during this developmental stage (Powers et al., 1989; Umberson, 1992).

Friendship quality and support. Friendships play an integral role in an individual's overall development and well-being and provide one of the most fundamental components of social support (Barry et al., 2016; Collins & Van Dulmen, 2006). Since one tends to spend a considerable amount of time with one's friends

(Collins & Laursen, 2004), friendships provide several distinct contributions to a person's life throughout the stage of emerging adulthood (Barry & Madsen, 2010). Friendships aid in identity development and can provide feelings of worth. The quality of having at least one close friendship to self-development and connectedness was tested in a longitudinal study by Kopala-Sibley and colleagues in 2015 on a total of 82 Canadian participants between the ages of 18–20. Each participant was instructed to bring a friend "they felt closest to" to complete the study with them. During the main study, participants completed all the study measures with their friend only completing a relational support inventory. The results indicated that the role of close friendships benefitted individuals overall and significantly decreased depressive symptoms, suggesting that over time the quality of at least one significant friendship can impact the development of a person's sense of self and worth.

Friendships also provide insight into how relationships should function and opportunities to see perspectives outside of one's own (Barry & Madsen, 2016). Friendships during emerging adulthood are deeply significant because they provide companionship, intimacy, interdependence, and the development of emotional intimacy skills that eventually help individuals in future romantic relationships. Researchers of a 2009 study collected data from 710 emerging adults between the ages of 18 and 26 and examined the intersection of identity development and achievement of adulthood criteria – the extent to which individuals feel they have become self-reliant and can comply with societal norms for adulthood – with qualities of close relationships with romantic partners and friends (Barry et al., 2009). Participants were drawn from an ongoing study called Project READY (Researching Emerging Adults' Developmental Years), where

they completed questionnaires about friendships, romantic partnerships, and aspects related to their perceived adult status. Results indicated that high quality romantic relationships were positively associated with several achieved adulthood criteria, while in contrast having achieved higher levels of adulthood criteria were associated with poorer friendship qualities. An unexpected finding of the study was that the adult achievement criterion of interdependence was positively related to the specific friendship qualities' of affection and relationship satisfaction, suggesting that the transition to adulthood benefits from specific friendship qualities. Further research is needed to investigate the nuances of friendships during this stage because they do tend to be other-oriented.

The constant transitions and life events in emerging adulthood tend to impact the maintenance and quality of friendships during emerging adulthood (Asendorpf & Wilpers, 1998; Wrzus et al., 2013). Friendships often help one manage stress associated with the ever-occurring changes of this developmental stage (Miething et al., 2016), and instability in friendships during emerging adulthood are shown to be associated with higher levels of depressive symptoms (Chow & Ruhl, 2014; Meithing et al., 2016; Sheets & Craighead, 2014). Lapierre and Poulin (2019) utilized data from a longitudinal research project involving 268 Canadian students in the province of Quebec to examine the link between friendship instability during emerging adulthood and depressive symptoms. The interviewers focused on participants between the ages of 22 and 26, and the findings indicated a positive association between depressive symptoms and friendship instability in maintenance of the relationship. This study required the participants to name three best friends over a five-year period to determine consistency and longevity of relationships, and depressive symptoms were measured using the Center for

Epidemiological Studies Depression Scales. However, the study did not examine the quality of those relationships. More research on the role of friendship in psychological adjustment in young adulthood, especially in terms of friendship quality, is needed in order to provide further correlations.

Friendships throughout an individual's life are both beneficial and complex (Hartup and Stevens,2012; Wrzus et al., 2012), especially during the transition to adulthood (Arnett, 2004, 2007, 2019). This developmental stage is marked by a surge for independence and personal creation of a social network (Arnett, 2019; Arnett & Fisher, 2014). The overall well-being of a person can be positively or negatively impacted by the quality of friendships they have (Barry et al, 2009). This study aims to add to the literature on the role of friendships on depressive symptoms for emerging adults.

Family relationship quality and support. Another major aspect of an individual's social support dynamic is the quality and richness of relationship support from family. During emerging adulthood, parents are far less involved in their children's lives compared to earlier stages of development. At the same time, family is perceived as an important source of social, economic, and emotional support during emerging adulthood (Garcia-Mendoza et al., 2020). Previous research has mostly focused on the quality of familial relationships during adolescence (Weymouth et al., 2016), and most findings have shown that a positive family relationship buffers against several negative outcomes, while conflictual relationships are associated with significant maladjustment (Burt et al., 1988; Collins & Laursen, 2004). Research examining each of these parent–adolescent relationship factors provides insight into their associations with adolescent mental health outcomes—specifically, higher levels of closeness in the parent–adolescent

relationship have been found to be inversely associated with adolescent internalization and externalization of symptoms of depression (Ge et al., 2009; Palosaari et al., 1996). Familial closeness has also been shown to be inversely linked to adolescent antisocial behaviors (Vieno et al., 2009), and Fanti and colleagues (2008) found that adolescent adjustment is influenced by the strengths of the parent–adolescent bond. Researchers (Hair et al., 2008) found positive influences from parent–adolescent relationships on mental well-being and delinquency was mitigated by family routines, parental monitoring, and parental supportiveness. Using attachment theory and person-centered theory frameworks, Withers and colleagues (2016) employed the Home Observation for Measurement of the Environment (HOME) tool to measure closeness, communication, autonomy, and conflict to differentiate the quality of the parent–adolescent relationship in a sample of 498 high-risk adolescents and their parents/guardians. Results suggested that parent–adolescent relationships classified as "secure" were associated with less adolescent depression, delinquency, and aggression.

Research has yet to explore the connection of closeness during the phase of emerging adulthood, though, and this thesis makes an effort to examine the association between family support and depressive symptoms during this transition phase. There is limited research analyzing family relationships during emerging adulthood (Parra et al., 2013), but there is an understanding that the quality of the relationship in this developmental stage is influenced by the continuity of the relationship from earlier stages (Thornton et al., 1995; Tubman & Lerner, 1994). Major consensuses also point to the notion that overall well-being of young people during emerging adulthood is strongly related to the quality of their family relationships (Roberts & Bengston, 1993), and it has

been suggested that family comprises a fundamental system of support for emerging adults (Holdsworth & Morgan, 2005). Studies have consistently found that continuity of the parent–child relationships from childhood into emerging adulthood plays an essential role in personal well-being, especially if the quality is maintained as it was in earlier, formative years (Duineveid et al., 2017). In a longitudinal study that observed the long-term effects of parenting practices during adolescence on well-being outcomes in young adulthood, Aquilino and Supple (2001) found that strong parent–child relationships with high levels of support and affection positively impacted overall psychological well-being in young adults. Lindell and Campione-Barr (2016) reviewed the continuity and change in families as they transition from adolescence to emerging adulthood from a family systems and longitudinal perspective, observing positive and negative qualities of parent–child and sibling relationships and interactions. Overall, there were three main themes discovered from their review: emerging adults have less physical contact with their families of origin, the transitional nature of this stage encompasses lifestyle changes that are key catalysts of continual change in the family relationships, and the quality of the relationships are positively improving due to the relationships remaining stable in the midst of all the personal change. The present study aims to further explore the quality of family relationships during this stage and its association on depressive symptoms.

Family cohesion. A fundamental aspect of family life and a foundational factor related to family relationship quality is family cohesion (Beavers et al., 1975; Bloom, 1985; Olson et al., 1983; Skinner et al., 1983). Family cohesion is often operationally defined as shared affection, support, helpfulness, and caring amongst family members (Harris & Molock, 2000). Barber and Buehler (1996) previously examined the nuances of

family cohesion on adolescent functioning. Since past research constantly synthesizes the two constructs, Barber and Buehler endeavored to highlight the distinction between family cohesion and enmeshment with their study sample of 471 participants from the 1990 Tennessee Adolescents in Families Project in Knox County. Their findings determined that lower levels of cohesion were predictive of four types of internalized and externalized problems in adolescents (aggression, anxiety/depression, delinquency, and withdrawal). Previous research had found that adolescent happiness and mental well-being can also be associated with an adolescent's perception of family cohesion (Crespo et al., 2011; Rask et al., 2003). As such, youth living in families with low levels of cohesion tend to present higher levels of depressive symptoms (McKeown et al., 1997).

Family cohesion is also associated with higher levels well-being and lower levels of stress and depression in emerging adults (Harris & Molock, 2000; Johnson et al., 2010; Reinherz et al., 2003). During this stage of life, parents tend to be less involved but still remain an important source of social, economic, and emotional support (Arnett, 2004). Emerging adults who reported higher levels of family cohesion, parental affection, and emotional closeness during adolescence felt closer to their parents in adulthood (Harris & Molock, 2000; Rossi & Rossi, 1990), and this heralded better and stronger adjustment during the college transition. In an effort to explore how familial connections and support ebb and flow throughout emerging adulthood, a group of researchers conducted a longitudinal study following 90 participants over a 10-year period from adolescence into emerging adulthood through schools in southern Spain (Parra et al., 2013). Their findings demonstrated that conflicts in parent–child relationships tend to decrease over time as the child matures, and cohesion was seen as a variable that added to the positive continuity of

the relationship. Family cohesion showed significant negative associations with emotional autonomy as emerging adults struggle to define themselves, and the associations were much more pronounced as participants moved from adolescence into emerging adulthood as negotiations for autonomy are constantly being made (Aquilino, 1997; Arnett, 2014). In a similar vein, individuals work throughout this transition stage to maintain strong emotional bonds to their families of origin (Aquilino, 2006; Arnett, 2004). This study will work towards examining the tenants of family cohesion and how the perception of the level of cohesion relates to an individual's depressive symptoms.

Age as a Factor in Emerging Adulthood

Emerging adulthood hovers between the ages of 18–25, but significant differences can be seen throughout this period of development, as there are many components to traditional transitions into adulthood that are attributed to older emerging adults (ages 22–25). Gaining full-time employment, getting married, and becoming a parent are several of those components, as well as completing higher education (Booth et al., 1999; Cohen et al., 2003; Macmillan & Copher, 2005; Oesterle et al., 2010).

In Western cultures, individuals often choose enrollment in post-secondary institutions as a tool to pause their personal developmental tasks and maintain friendships (Tinto, 2012), as well as fulfill familial expectations and prepare for specialized employment opportunities. Enrollment trends have also significantly increased (Baum et al., 2011) over the past four decades in relation to population. The overall college enrollment rate for ages 18 to 24 increased from 35% in 2000 to 41% in 2018, and in 2011 the percent of overall adults in the U.S. enrolled in undergraduate programs

between the ages of 18–19 and 20–24 were 71% and 40%, respectively (McFarland et al., 2019).

Depression is one of the most common diagnoses made by mental health professionals dealing with post-secondary students (Marcotte, 2013). The impact of mental health-related problems on university students can be profound and can include negative effects on social interactions and interpersonal issues (Al-Dabal et al., 2010; Collins & Mowbray, 2005; Heiligenstein & Guenther, 1996). Studies have shown that college students seek informal support from family members, and they would prefer to disclose mental health concerns to a parent (Atkinson & Lowe, 1995; Ciarrochi et al., 2003; Constantine & Arorash, 2001; Turner et al., 2007). Emerging adult college students who rely on their parents for social support are more motivated in their academic work, more satisfied with their overall college experience, and able to minimize mental health stressors (Creamer & Laughlin, 2005; National Survey of Student Engagement, 2007; Simmons, 2008; Wodka & Barakat, 2007).

The transition from the pursuit of education into entering the workforce is commonly rife with difficulty as emerging adults try to secure full-time, well-paid employment, especially after the 2008 recession (Cassidy & Wright, 2008; Murphy et al., 2010). The inability to secure such employment has been found to contribute negatively to mental health and personal well-being outcomes (Creed, 1999; Creed & Moore, 2006; Galambos et al., 2006), and unemployment rates have been historically higher among youth and emerging adults than older adults in many regions of the world (Bernard, 2013). Domene and his colleagues (2016) longitudinally explored the presence of depression symptoms associated with changes in employment characteristics during the

transition into the workforce. The study drew from Canadian, population-based survey that followed children's development into early adulthood, and the researchers hypothesized that full-time employment would be associated with lower levels of depression over time. The final sample consisted of 793 participants, and the findings proved that depression symptoms on average significantly decreased over time, and full-time employment was also associated with lower initial levels of depression and a faster decrease in symptoms. These results suggest that is important to consider how employment is connected to and affects depression symptoms over time.

As individuals attempt to successfully transition through this stage towards young adulthood, it may be warranted to consider how the relationship between depressive symptoms and social support differ based on age, especially related to the differences between how younger emerging adults manage and process depression from older emerging adults. There are distinctions to be considered concerning negotiations being made socially as younger emerging adults strive to find the balance of autonomy and need for family versus older emerging adults making efforts to create new and permanent social supports on their own (Tanner, 2006). The present study will explore whether support from families is stronger for younger emerging adults, and whether support from friends is stronger for older emerging adults.

Theoretical Framework

The focus of this study is to understand how support or lack thereof from family and friends could be associated with symptoms of depression in emerging adulthood. For this reason, the family systems theory is particularly important for this study, given the significance of understanding mental health issues in the dynamics of relationships (von

Bertalanffy, 1968). The Family Systems Theory seeks to explain human functioning in context with one's relationships with family (Watson, 2012). This theory has four core assumptions: 1) the system components are interconnected, 2) a system can only be understood when looking at it from its entirety, 3) all components of the system affect each other, and 4) systems are not objective (White et al., 2015). It also includes eight key concepts—system, boundaries, rules of transformation, feedback, variety, equilibrium, system levels, and subsystems—as fundamental components to the theory (White et al., 2015). The theory focuses on the observation of human behavior and functioning at several levels, especially individuals in the context of the relationship systems to which they belong, the members of the systems in relation to one other, and the systems overall (Bregman & White, 2011).

Family Systems Theory claims that functional and dysfunctional family processes are more clearly defined during times of stress. Transitions through different life stages can put families under stress because the relationship needs to adapt to a new, sometimes different, way of functioning. As such, how changes are processed within the system during the transition into adulthood influences how a person relates to their family members in the aftermath. When observing the association between family functioning and depressive symptoms among young adults, the cohesion and closeness of the emerging adult to his or her family may relate to how he or she adjusts and functions with their depressives symptoms.

Using the perspective of the Family Systems Theory, it has been proposed by Minuchin (1985) that families in developmental transitions often make negotiations; individuals during the transition to adulthood develop dual needs to facilitate the process

of their individuation from their families and maintain a feeling of connection at the same time (Bowen, 1978; Minuchin et al., 1975). The need for increased autonomy during this period challenges parents to shift their roles from behavior management to social and emotional support. Carter and McGolderick (1999) launched Bowenian concepts through a family life cycle perspective thorough transitions of expansion, contraction, and realignment of the relationship system to support the entry, exit, and development of family members (Gehart, 2016; Nichols, 2013). They posited that the primary task for emerging adults is to separate from their families without cutting off or fleeing to an emotional substitute.

Family Systems Theory is relevant to the aims of this study due to its compelling argument that an individual is deeply influenced by their family. According to this systems theory, families are interconnected systems that constantly share experiences and messages (Bowen, 1976; Kerr & Bowen, 1988), and individuals function and define themselves in the context of significant relationships (Skowron et al., 2004). These factors compel the focus of this study to examine whether there is an association between familial cohesion and depressive symptoms.

Objectives and Hypotheses

The present study aimed to answer two distinct research questions: 1) are perceived levels of familial cohesion and social support from friends associated to depressive symptoms during emerging adulthood? and 2) Does the relationship between the two social support categories and depressive symptoms differ because of age?

Based on Family Systems Theory, it was hypothesized that there would be a negative relationship between perceived levels of social support from friends and levels of family cohesion with depressive symptoms among emerging adults.

Hypothesis 1: Higher levels of perceived familial cohesion would be associated with lower levels of depressive symptoms.

Hypothesis 2: Higher levels of perceived social support from friends would be associated with lower depressive symptoms.

Hypothesis 3: Age would moderate the association between familial cohesion and depressive symptoms, such that younger emerging adults with higher levels of perceived familial cohesion would present with lower levels of depressive symptoms in comparison to older emerging adults.

Hypothesis 4: Age would moderate the association between social support from friends and depressive symptoms, such that older emerging adults with higher levels of perceived social support from friends would present with lower levels of depressive symptoms in comparison to younger emerging adults.

Chapter 3: Methods

Sample and Procedures

Procedure. This current study utilizes a secondary analysis of preexisting data collected between 2000 and 2015 at the Center for Healthy Families (CHF), an outpatient couples and family therapy training clinic housed within the Department of Family Science at the University of Maryland. Students in this program are supervised by licensed AAMFT-approved supervisors. The data was obtained from individuals that sought therapy at the CHF. Data from a total of n = 372 participants are analyzed in the present study.

Participants. The data used for this research is from individuals who sought individual or family therapy services at the CHF between 2000 and 2015 ranging in age from 18 to 25. In this dataset, there was originally a total of 247 female and 130 male participants in that age range; five were excluded as they did not complete the majority of the measures of this study, resulting in n= 372.

Measurement Variables

Independent Variables

Familial Cohesion (see Appendix A). The measure for familial support was adapted from the Self-Report Family Inventory (BFI), a 36-item instrument that looks at the individual's perspective of their family functioning. This study focuses on the subscale of cohesion, composed of five questions, specifically items that focus on family togetherness and satisfaction received from inside the family-BFI_cohesion. Participants

were asked to indicate on a 5-point Likert scale the degree to which they agree with each statement (1= *fits our family very well* to 5 = *does not fit our family*). The statements for cohesion are as follows: 1) *Our family would rather do things together than with other people* (reverse-coded); 2) *Our happiest times are at home* (reverse-coded); 3) *Family members go their own way most of the time*; 4) *Our family members would rather do things with other people than together*. The fifth item has a response scale specific to the statement and was also reverse-coded: 5) *On a scale of 1 to 5, I would rate my family as: 1= No one is independent. There are no open arguments. Family members rely on each other for satisfaction rather than on outsiders;* 3= *Sometimes independent. There are some disagreements. Family members find satisfaction both within and outside of the family;* 5= *Family members usually go their own way. Disagreements are open. Family members look outside of the family for satisfaction.* The sum of the responses to these five items informed the creation of an index for familial support, with higher scores indicating higher family closeness. For the present study, this scale was found to be reliable, with Cronbach alpha scores of 0.81.

Social support from friends (see Appendix B). The measure for social support from friends was adapted from SSFR (friends) – measure of perceived social support. The measure includes 20 statements that refer to feelings and experiences that occur in their relationship with friends. Participants were asked to indicate on a 5-point Likert scale the degree to which they agree with each statement (1=*yes* to 5=*no*), with six of the items reverse coded. Examples of items are as it follows: 1) *My friends give me the moral support I need;* 2) *Most other people are closer to their friends than I am* (reverse-coded); 3) *My friends enjoy hearing about what I think;* 4) *Certain friends come to me*

when they have problems or need advice; 5) *I rely on my friends for emotional support.* Participants scored on this scale were summed up, with higher scores reflecting higher perceived levels of social support from friends. For the present study, this scale was found to be reliable, with Cronbach alpha score of 0.92.

Dependent Variable

The depressive symptoms measure used in this study is the Beck Depression Inventory (BDI) scale (see Appendix C). This 21-item self-report questionnaire assesses symptoms of depression as they occurred in the past week. The items are answered on a 4-point Likert scale (from *0 = no experience of symptom* to *3 = strongest level of symptom experienced*). Statements include: 1) *I do not feel sad. I feel sad. I am sad all the time and I can't snap out of it. I am sad or unhappy that I can't stand it.* 2) *I do not feel like a failure. I feel I have failed more than the average person. As I look back on my life, all I can see is a lot of failures. I feel I am a complete failure as a person.* 3) *I don't have any thoughts of killing myself. I have thoughts of killing myself. I would like to kill myself. I would kill myself if I had the chance.* 4) *I make decisions about as well as I ever could. I put off making decisions more than I used to. I have greater difficulty in making decisions than before.* 5) *I Can sleep as well as usual. I don't sleep as well as I used to. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. I wake up several hours earlier than I used to and cannot get back to sleep.* The BDI has been tested and found to have high internal consistency and validity as well as acceptable reliability (Beck et al., 1988). Cutoff scores range from four categories: a score of 10 and below indicating none to minimal depression, 10–18 indicating mild to moderate depression, 19–29 indicating moderate to severe depression, and 30–63 indicating severe depression (Beck et al.,

1988). For the present study, this scale was found to be reliable, with Cronbach alpha scores of 0.88.

Moderator Variable

Age. The participants were asked to provide their date of birth in the initial assessment paperwork when they sought therapy services at the CHF. Participants were split into two categories: younger emerging adults between 18-21 and older emerging adults between 22-25.

Control Variables

Gender. The measure for and reporting of social support and depressive symptoms may be influenced by gender. Research has indicated that women experience higher levels of depressive symptoms (Lamis & Lester, 2013; Pettit et al., 2011; Rivera, 2007) and that women perceive higher levels of global support than men (Adamczyk & Segrin, 2015; Campos et al., 2014; Galambos et al., 2004). Therefore, controlling for gender is an important consideration in the overall analysis.

Occupation. The measure for and reporting of social support and depressive symptoms may be influenced by occupation. Within the emerging adulthood demographic there are some who choose to attend post-secondary education and some who enter directly into the workforce. Previous research has indicated that there is an association between depressive symptoms and college adjustment (Mahmoud et al., 2015; Villatte et al., 2017), as well as unemployment post-graduation (McGee & Thompson, 2010). Occupation was initially planned as a control variable in this study.

Race and Ethnicity. Arnett (2000, 2019) highlighted that the experience of transition to adulthood might vary depending on the cultural background of individuals. For this reason, race was initially planned as a control variable.

Chapter 4: Results

Sample Description

After removing five participants who did not respond to the majority of the measures of the present study, the final sample resulted in 372 participants. Of those reporting their gender, 65.3% were female and 34.4% were male. In regard to age, 52.6% were between 18 and 21 years old and 47.4% were between 22 and 25 years old (M = 21.32, SD = 2.62), with almost half of the participants being students (48.9%). With respect to race and ethnicity, respondents reported being White (36%), African American (33.6%), Hispanic (16.7%), "Other or Multiracial" (7.9%), and Asian/Pacific Islander (5%).

Preliminary Analysis

Cronbach alphas reliability analyses were calculated for each of the study variables, as well as mean, range, and standard deviation (see Table 1). Both independent variables had acceptable Cronbach alphas: The modified Self-Inventory Report for - Cohesion Subcategory (BFI_cohesion) and Social Support from Friends assessment (SSFR) had Cronbach alpha scores of 0.81 and 0.92, respectively. The Beck Depression scale had a Cronbach alpha score of 0.88, and the sample fell into the mild to moderate depression range with a mean score of 15.77. Table 1 presents the minimum, maximum, means, standard deviations, kurtosis, and reliability scores for each of the measures in the study.

Table 1. Scale Distributions

	Minimum	*Maximum*	*Means*	*Standard Deviation*	*Kurtosis*	*α*
Social Support – Family (BFI_cohesion)	5.00	25.00	13.60	4.80	–0.54	0.81
Social Support – Friends (SSFR)	20.00	96.00	46.09	16.35	–0.09	0.92
Beck Depression Inventory (BDI)	0.00	48.00	15.77	9.67	0.57	0.88

n = 372.

Prior to running analysis, cases of missing values were replaced with the respective variable means. Prior to testing the hypotheses of this study, Pearson's correlations were calculated among the study variables to verify if there were significant associations between the independent variables (Social Support – Family – BFI_cohesion; and Social Support – Friends – SSFR), the control variables (gender, age, race, and occupation), and the dependent variable (depressive symptoms – Beck Depression Inventory – BDI). It was found that race and occupation were not significantly associated with the dependent variable, depressive symptoms – BDI. For this reason, these control variables were not included in subsequent analyses (see Table 2).

Table 2. Correlations among Variables (N=372)

	1	*2*	*3*	*4*	*5*	*6*	*7*
1. ***Gender***	—						
2. ***Age***	–0.03	—					
3. ***Race***	0.01	–0.09	—				

4. ***Occupation***	0.03	0.39**	0.07	—			
5. ***Social Support – Family (BFI_cohesion)***	–0.06	0.01	–0.30	–0.004	—		
6. ***Social Support – Friends (SSFR)***	0.16**	0.003	–0.18	–0.001	-0.03	—	
7. ***Beck Depression Inventory (BDI)***	–0.12*	0.07	0.03	0.01	–0.17**	0.17**	—

*$p < 0.05$ level (two-tailed).
**$p < 0.01$ level (two-tailed).

Primary Analyses

To address the first two hypotheses of this study, a multiple hierarchical regression analysis was conducted, where gender was entered as a control variable in the first step, familial support as the second step, and support from friends as the final step. Depressive symptoms were included as the dependent variable. Hypotheses 1 and 2 were being tested: higher levels of perceived familial cohesion would be associated with lower levels of depressive symptoms, and higher levels of perceived support from friends would be associated with lower depressive symptoms.

Results indicated that regression models were significant for both familial cohesion – BFI_cohesion (F (2, 351) = 9.46, $p < 0.001$) and social support from friends – SSFR (F (3, 351) = 12.28, $p < 0.001$). Results did support Hypothesis 1 regarding the direction of the association between the independent variable and the dependent variable. It was predicted that the independent variable, familial cohesion (BFI_cohesion), would have a negative association with depressive symptoms, and results did indicate significant negative association between familial cohesion – BFI_cohesion ($\beta = –0.18$, $t = –3.48$, $p < 0.001$) and depressive symptoms. Results did not support Hypothesis 2, though, regarding the direction of the association between the independent variable and the dependent

variable. It was predicted that the independent variable social support from friends – SSFR would have a negative association with symptoms of depression, but results indicated a significant positive association between social support from friends – SSFR ($\beta = 0.21$, $t = 4.13$, $p < 0.001$) and depressive symptoms (see Table 3).

Table 3. Multiple Regression

Model	*Variable*	*B*	*SE*	*β*	*t*
1	Gender	–2.77	1.08	–0.14	–2.57*
2	Social Support – Family (BFI_cohesion)	–0.38	0.11	–0.18	–3.48***
3	Social Support – Friends (SSFR)	0.13	0.03	0.21	4.13***

Notes. Gender: Females = 1. Males = 0. (F (1,292) = 15.51, $p < .05$).
Step 1: Gender; Step 2: Gender, Social Support – Family (BFI_cohesion); Step 3: Gender, Social Support – Family (BFI_cohesion), Social Support – Friends (SSFR).
*$p < .05$.
**$p < .01$.
***$p < .001$.

Initially, Hypothesis 3 proposed that age would moderate the associations between familial cohesion and depressive symptoms, and Hypothesis 4 anticipated that age would moderate the associations between social support from friends and depressive symptoms. However, preliminary analysis based on bivariate correlations indicated that age was not associated with any of the study variables, including the dependent variable of depressive symptoms (see Table 2). Therefore, age was not included in further analysis of this study, and opposed to what was predicted, age did not moderate associations between familial cohesion and depressive symptoms or social support from friends and depressive symptoms.

Chapter 5: Discussion

The overall purpose of the present study was to add to the growing body of literature and understand more about the nuances of the emerging adulthood stage of development that Arnett (2006, 2014) claims occurs between adolescence and adulthood. More specifically, the research questions investigated in the present study were: 1) how do perceived levels of social support from friends and levels of familial cohesion relate to depressive symptoms, and 2) does the relationship between perceived levels of social support and depressive symptoms differ because of age?

According to WHO, depression has been categorized as the leading cause of disability worldwide and is considered a significant clinical challenge. One of the main reasons why individuals sought services at the Center for Healthy Families (CHF), where the data was obtained, was for concerns of depression and anxiety. The mean BDI score for the participants in this study was close to 16, meaning that participants of this study scored within the mild to moderate range of depression. This supports the notion that depression is consistently a concern for young people transitioning into adulthood, possibly due to personal uncertainty and identity formation associated with this time of life (Kuwabara et al., 2007).

It was predicted that the independent variables of social support (from family and from friends) would have negative associations with symptoms of depression in emerging adults and that higher perception of positive levels of family cohesion and social support from friends would be associated with lower levels of depressive symptoms. Results varied in support of the two primary hypotheses regarding the direction of the associations between the independent variable and the dependent variable. Specifically,

Hypothesis 1 predicted that perceived familial cohesion would be negatively associated with symptoms of depression, and the results did support this hypothesis. The notion of observing an individual's behavior and functioning in the context of their larger encompassing system (Bregman & White, 2011) is seen in the results of this study from the Family Systems perspective. The goal of Family Systems is to understand how family dynamics may interplay with individual functioning, and the findings revealed that higher levels of perceived familial cohesion were associated with lower levels of depressive symptoms, as supported by previous research. One of the major assumptions of the Family Systems framework is that all parts of the system are interconnected and the system's behavior affects and is affected by its environment (White et al., 2015); family functioning patterns can have an impact at the individual level through the intergenerational transmission process, and this study continues to support this idea.

The findings of this study support previous research that have found high levels of perceived family support to be associated with lower levels of depressive symptoms (Roberts & Bengston, 1993; Thornton et al., 1995; Tubman & Lerner, 1994). The results are consistent with previous studies, including one conducted in 2011 where researchers found that emerging adulthood was characterized by decreasing depressive symptoms in tandem with increased levels of social support (Petit et al., 2011). Support from families often buffers any adverse associations between stress and depressive symptoms, according to findings by Lee and Dik (2016). The results of the present study validate previous research in familial cohesion and closeness (Corona et al., 2005; Vieno et al., 2009) and provide insight to the limited research analyzing family support during the transition to adulthood (Parra et al., 2013). Overall, the consensus is that the personal

well-being of an emerging adult is highly related to the quality of his or her family relationships (Roberts & Bengton, 1993). This study provides additional evidence that family is a fundamental source of support (e.g., Holdsworth & Morgan, 2005), and that positive qualities of the relationships continues to be essential for adequate adjustment during the transition to adulthood (e.g., Parra et al., 2015; Power et al., 1989; Umberson, 1992).

Hypothesis 2 predicted that social support from friends would be negatively associated with symptoms of depression. Results did not support this hypothesis and, in fact, the association between social support from friends was opposite to what was predicted: higher levels of perceived social support from friends were associated with higher levels of depressive symptoms, beyond what is already accounted for by support from one's family. The assumption about friendships during the transition to adulthood was that support from friends may potentially fill the gap of any possible missing support from a person's family (Collins & Madsen, 2006), as social relationships do have significant implications on mental and physical health. It was surprising that results of the present study did not support most of what has been previously suggested in the literature.

Allen (2008) examined the degree to which the domains of family and friendship blend together, the shifts that occur, and the boundaries that develop from these very distinct relationships, which may contribute to the explanation behind the results of the present study. While it is possible that perceived social support protects individuals from the adverse effects of stress and the symptoms of pathology, it is equally as plausible that symptomatic participants of this study would be far more progressed in their

symptomology with little to no support (Procidano & Heller, 1983). Since we do not know the status and level of the relationship in reference, it is also plausible that the friend in question may have his or her own personal mental health issues that could affect the results of this study. A diagnostic criterion of major depressive disorder according to the DSM-5 (American Psychiatric Association, 2013) is "markedly diminished interest or pleasure in all or almost all activities most of the day" and individuals with greater depressive symptoms reported somewhat fewer positive social interactions and significantly more negative social interaction (Steger and Kashdan, 2009). The sample for this study fell into the mild to moderate levels of depressive symptoms and all of these factors may contribute to the results of the study.

It is also important to note that the SSFR assessment measure required participants to think about their friendship roles across a wider span of time than the one-week requirement of the BDI assessment. Additionally, for emerging adults, the line between friend and romantic partner can often be blurred (Crouter & Booth, 2006), though noteworthy research findings generally indicate greater focus on romantic relationships than friendships during emerging adulthood (Barry et al., 2009; Carbery & Buhrmester, 1998).

However, the unexpected relationship between perceived levels of friendship support and depressive symptoms may also be explained by some of the defining markers of emerging adulthood. The dimensions state that emerging adults are both in an "age of instability" and "age of self-focus." Respectively, these concepts suggest that as emerging adults explore, they feel an equal sense of independence and insecurity while they experience change (Reifman et al., 2007). These two categories indicate that

friendships and levels of intimacy and social support vary constantly (Hartup & Stevens, 1999) and can therefore somewhat explain the rise in depressive symptoms with perceived levels of high social support.

Hypotheses 3 and 4 in this study predicted that age would moderate the association between social support and depressive symptoms, such that lower levels of depressive symptoms would be presented in younger emerging adults (18–21) in relation to high levels of support from family, and lower levels of depressive symptoms would be presented in older emerging adults (22–25) in relation to high levels of support from friends. However, our analyses did not find significant associations between age and depressive symptoms, even though previous research found that the constant transitions into significant adult milestones (employment, education, long-term relationships, etc.) are related to negative emotional well-being (Bernard, 2013; Booth et al., 1999; Domene et al., 2016). It can be assumed that there was no association found between age and symptoms of depression for the following: this study did not include participants from other developmental stages, and although the sample was composed of those aged 18–25, the age frequency was 53% at 21 years and below within the sample and therefore there may not have been enough variability to find significance. Other studies have compared emerging adults to other developmental stages (Arnett & Mitra, 2018; Bynner, 2005), and the present study focused on a single age group, which could be considered a drawback.

Limitations

The main limitation of this study is that the assessments used were focused specifically on the individual and did not include participation other family members, and friends. Solely looking at the individuals apart from their family does not indicate how

the participants' depressive symptoms were exhibited within the context of their family unit, especially when taking the Family Systems perspective into account. Additional assessment of an individual's family is necessary to truly understand the family's functioning and the possible development of depressive symptoms in the individual.

Another limitation of the present study is that the participants were not a random sample selection—they were all individuals actively seeking treatment for mental health concerns. This can explain the mild to moderate levels of depressive symptoms among the study participants. The cross-sectional nature of this study makes it impossible to draw conclusions in regard to the quality of the family relationship throughout other developmental transitions to see if there are moments when an individual had other moments of high depressive symptoms. There also was not a focus on familial conflict, and the same can be said concerning the level of social support from friends; longitudinal study would allow for an examination of the depressive symptoms across time.

Furthermore, it was unknown as to what level of friendship the participants considered while completing the assessment nor the mental health status of the friends they referenced. The timing of the measurements were also a limitation source for this study. The BDI assessment asked clients to think of symptoms within the last week, while the BFI_cohesion (family cohesion) and SSFR (support from friends) required clients to think about support across the lifetime. In respect to moderation of age, the given sample could not see any association between age and depressive symptoms as there were no other age group samples to compare with the sample in this study, posing as another limitation to this study.

Future Research Implications

The results of the present study highlight several areas warranting further study. A longitudinal study to determine if there is a significant impact on an individual's perceived level of familial cohesion and social support from friends changes across time. Other major personal transitions, including the individual's other family members' assessment scores, to see how his or her level of depressive symptoms varied would provide useful data. Future research should also focus on the role of gender in depressive symptoms during emerging adulthood as that was a noteworthy variable in this study's analysis. Prospective research can also place focus on the cultural components that may relate to depressive symptoms and familial cohesion, especially comparing different races and ethnicities. It would be additionally be beneficial to include a more generalizable sample as opposed to a sample of individuals already seeking clinical treatment.

One of the goals of this study was to explore the relationship between social support and depressive symptoms with age as a moderator. Although the present study did not find any significance in relationship between the age and the dependent variable of depressive symptoms, future research should certainly compare other developmental stages to the emerging adulthood sample. Finally, assessing for the quality of the friendship in reference by incorporating clear definitions in what is defined as a "friend" and having individuals identify the level of relationship in their friendships, as well as finding a way to explore and measure the depressive symptom levels within the friend group, would make for illuminating results.

Clinical Implications

The results of the current study have important implications for clinicians working with emerging adults reporting moderate to high depressive symptoms. Clinicians may find it helpful to discuss family perceptions and dynamics even if solely working with an individual. Considering the findings regarding family support and its association with depressive symptoms, it may even be beneficial to include the scores and presence of the entire family system in order to better assist the individual.

Clinicians working with this population should also consider the impact of cultural implications. One of the major critiques of emerging adulthood suggests that it does not incorporate the experiences of families that are culturally diverse (Arnett, 2014); when research actually suggests that individuals negotiate this differently across cultures (Raffaelli et al., 2013). The results of this study showed that families play a pivotal role in overall mental health of emerging adults and should be considered to create interventions. Clinicians should not diminish the collectivist attitudes of clients that come from non-American backgrounds and cultures. They should work to be both culturally sensitive and adept at the needs of the emerging adult they are treating, taking into consideration their culture of origin as well.

One of the major theoretical models in family therapy is Bowen's Multigenerational System's Theory, and clinicians can use tenants of this model along with the results of this study to provide proper treatment to clients. Bowen's Theory suggests that differentiated individuals develop an ability to separate from the emotional process through family interactions (Kerr & Bowen, 1988), and the higher levels of differentiation that an individual has accounts for better processing of and coping with

depressive symptoms (Bowen, 1978). Elieson and Rubin (2001) conducted a study focusing on the relationship between differentiation levels and depression symptoms, and their findings supported previous research suggesting people with lower levels of differentiation of self tend to exhibit more depressive symptoms (Green et al., 1986; Hurst et al., 1996). Aligned with Bowen, this study indicates that the healthier the family, the healthier the individual; however, it is important to note that this study did not specifically assess for the level of differentiation in participants or their family members. Based on Bowen's Theory, it could be suggested that aspects of family functioning are being transmitted to emerging adults, and as such those with lower levels of family cohesion presented with higher levels of depressive symptoms.

Intergenerational transmission process is a key concept of Bowen's Theory, hypothesizing that multiple family generations influence the same relationship patterns and areas of symptomology that develop within the nuclear family (Klever, 2004), and falls in line with the results of our study that higher levels of familial support were associated with lower depressive symptoms. The transitions of stressors in a system are contingent on the level of differentiation within each person in the family, and, in essence, the healthier the family, the healthier the individual (Bowen, 1974). As a fundamental Bowenian construct, differentiation is defined as the capacity to have a proper balance between both the tenets of individuality and togetherness (Ponappa et al., 2016). This construct relates to how depressive symptoms develop within members of the family (Bowen, 1978; Gavazzi et al., 1993; Sabatelli & Anderson, 1991). Low family differentiation levels are associated with problematic behaviors like depressive symptoms (Gavazzi et al., 1994), and parental differentiation is also related to poorer psychological

well-being in children up through young adulthood (Pillemer et al., 2010; Rauer & Volling, 2007).

Family can play a significant role in how an individual cope with depressive symptoms and how the family is handling their family member's transition to adulthood. Understanding the depths of an individual's friendships and how he or she defines those relationships is also important for prevention and treatment work. Clinicians can appropriately create treatment plans for clients when they know the client's social support team and their ability to help the client through his or her mental health issues.

Conclusion

The transition to adulthood is defined and marked by change and helping young adults navigate the uncertainties of this time is important in order to have a healthy, well-functioning society. Due to the complexity of this time period, it is common for individuals to develop mental health issues such as depressive symptoms, making it imperative to understand the factors that can mitigate them in emerging adults. Social support can be a leading aid in helping individuals prevent depressive symptoms, and this study primarily investigated the relationship between perceived levels of social support and depressive symptoms accordingly.

Distinctions between familial and peer relationship support were established in this study. High levels of familial cohesion were associated with lower levels of depressive symptoms showing that family members consistently remain important sources of support throughout an individual's lifespan. Unexpectedly, higher perceived levels of friendship support were associated with higher depressive symptoms. This addition to the literature should compel us to navigate how friendships can be better established and maintained to provide the support in symptomology that it seems to provide in perception.

Blood may in fact be thicker, more potent, and more impactful than water in regard to familial support compared to friendship support. However, future researchers and clinicians should continue to study how elements of social support can be used to both intervene and prevent mental health crises from occurring and assist individuals in navigating the intricacies of emerging adulthood with as little depressive symptoms as possible.

Appendices

Appendix A: Self-report and Family Inventory. (BFI_cohesion)

The self-report inventory measures familial support overall as well as five distinct subcategories: health competence, cohesion, conflict, leadership and expressiveness. For the purposes of this study the focus was on the subcategory of cohesion and only responses to questions 2,15, 19, 27, and 36 were used.

BFI[2]

Gender:_____ **Date of Birth:**_____ **Therapist Code:**_____ **Family Code:**_____

Directions: **For each question, circle the answer that best fits how you see your family now.**

	YES: Fits our family very well		**SOME:** Fits our family some		**NO:** Does not fit our family
1. Family members pay attention to each other's feelings.	1	2	3	4	5
2. Our family would rather do things together than with other people.	1	2	3	4	5
3. We all have a say in family plans.	1	2	3	4	5
4. The grownups in this family understand and agree on family decisions.	1	2	3	4	5
5. Grownups in the family compete and fight with each other	1	2	3	4	5
6. There is closeness in my family, but each person is allowed to be special and different.	1	2	3	4	5
7. We accept each other's friends.	1	2	3	4	5
8. There is confusion in our family because there is no leader.	1	2	3	4	5
9. Our family members touch and hug each other.	1	2	3	4	5
10. Family members put each other down	1	2	3	4	5
11. We speak our minds, no matter what.	1	2	3	4	5
12. In our home, we feel loved.	1	2	3	4	5
13. Even when we feel close, our family is embarrassed to admit it.	1	2	3	4	5
14. We argue a lot and never solve problems.	1	2	3	4	5
15. Our happiest times are at home.	1	2	3	4	5
16. The grownups in this family are strong leaders.	1	2	3	4	5
17. The future looks good to our family.	1	2	3	4	5
18. We usually blame one person in our family when things aren't going right.	1	2	3	4	5
19. Family members go their own way most of the time.	1	2	3	4	5
20. Our family is proud of being close.	1	2	3	4	5
21. Our family is good at solving problems together.	1	2	3	4	5

22. Family members easily express warmth and caring toward each other	1	2	3	4	5
23. It's okay to fight and yell in our family.	1	2	3	4	5
24. One of the adults in this family has a favorite child.	1	2	3	4	5
25. When things go wrong, we blame each other.	1	2	3	4	5
26. We say what we think and feel.	1	2	3	4	5
27. Our family members would rather do things with other people than together.	1	2	3	4	5
28. Family members pay attention to each other and listen to what is said.	1	2	3	4	5
29. We worry about hurting each other's feelings.	1	2	3	4	5
30. The mood in my family is usually sad and blue.	1	2	3	4	5
31. We argue a lot.	1	2	3	4	5
32. One person controls and leads the family.	1	2	3	4	5
33. My family is happy most of the time.	1	2	3	4	5
34. Each person takes responsibility for his/ her behavior	1	2	3	4	5

35. On a scale of 1 to 5, I would rate my family as: (Circle the number)

1	2	3	4	5
My family functions well together				My family does not function well together at all

36. On a scale of 1 to 5, I would rate my family as: (Circle the number)

1	2	3	4	5
No one is independent. There are no open arguments. Family members rely on each other for satisfaction rather than on outsiders.		Sometimes independent. There are some disagreements. Family members find satisfaction both within and outside of the family.		Family members usually go their own way. Disagreements are open. Family members look outside of the family for satisfaction

BFL.doc 8/1/11

Appendix B: Social Support from Friends Assessment (SSFR)

family service center
UNIVERSITY OF MARYLAND

SS (ASSESSMENT)

Gender: _____ **Date of Birth:** _____ **Therapist Code:** _____ **Family Code:** _____

SOCIAL SUPPORT

Directions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with **FRIENDS**. When thinking about friends, please do not include family members. For each statement there are five possible answers (1 through 5) ranging from "Yes" to "No." Please check the answer you choose for each item.

Yes				No		
1	2	3	4	5		
__	__	__	__	__	1.	My friends give me the moral support I need.
__	__	__	__	__	2.	Most other people are closer to their friends than I am.
__	__	__	__	__	3.	My friends enjoy hearing about what I think.
__	__	__	__	__	4.	Certain friends come to me when they have problems or need advice.
__	__	__	__	__	5.	I rely on my friends for emotional support.
__	__	__	__	__	6.	If I felt that one or more of my friends were upset with me, I'd just keep it to myself.
__	__	__	__	__	7.	I feel that I'm on the fringe in my circle of friends.
__	__	__	__	__	8.	There is a friend I could go to if I were just feeling down, without feeling funny about it later.
__	__	__	__	__	9.	My friends and I are very open about what we think about things.
__	__	__	__	__	10.	My friends are sensitive to my personal needs.
__	__	__	__	__	11.	My friends come to me for emotional support.
__	__	__	__	__	12.	My friends are good at helping me solve problems.
__	__	__	__	__	13.	I have a deep sharing relationship with a number of friends.
__	__	__	__	__	14.	My friends get good ideas about how to do things or make things from me.
__	__	__	__	__	15.	When I confide in friends, it makes me feel uncomfortable.
__	__	__	__	__	16.	My friends seek me out for companionship.
__	__	__	__	__	17.	I think that my friends feel that I'm good at helping them solve problems.
__	__	__	__	__	18.	I don't have a relationship with a friend that is as intimate as other people's relationships with friends.
__	__	__	__	__	19.	I've recently gotten a good idea about how to do something from a friend.
__	__	__	__	__	20.	I wish my friends were much different.

Appendix C: Beck Depression Inventory (BDI)

BDI

Name: _____ Gender: _____ Date of Birth: _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the ***PAST WEEK,*** **INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

--OVER PLEASE--

BDI 09/2014

10. 0 I don't cry any more than usual.
    1 I cry more than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I have ever been.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decision than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I cant' do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired more doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.
    I am purposely trying to lose weight. Yes ___ No ___

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches, pains, an upset stomach or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

BDI 09/2014

References

Adamczyk, K., & Segrin, C. (2015). An investigation of loneliness and perceived social support among single and partnered young adults. *Current Psychology, 35,* 674–689. https://doi.org/10.1007/ s12144-015-9337-7

Al-Dabal B., Koura M., Rasheed P., Al-Sowielem L. & Makki S. (2010) A comparative study of perceived stress among female medical and non-medical university students in Dammam, Saudi Arabia. *SQU Medical Journal 10*(2), 231–240.

Allan, G. (2008). Flexibility, friendship, and family. *Personal Relationships, 15*(1), 1–16.

American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders, 5th edition, DSM-5. Washington, DC: American Psychiatric Association.

Antonucci, T. C. (1994). A life-span view of women's social relations. In B.F. Turner & L. E. Troll (Eds.), *Women growing old* (p. 239–269). Sage Publications.

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, *55*(5), 469–480.

Arnett, J. J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties.* Oxford University Press.

Arnett, J. J. (2007). Socialization in emerging adulthood: From the family to the wider world, from socialization to self-socialization. In J. E. Grusec & P. D. Hastings (Eds.), *Handbook of socialization: Theory and research* (p. 208–239). The Guilford Press.

Arnett, J. J. (2019). Emerging adulthood. In R. Biswas-Diener & E. Diener (Eds.), *Noba textbook series: Psychology.* DEF Publishers.

Arnett, J. J., & Fisher, E. (2014). *Getting to 30: A parent's guide to the 20-something years*. Workman Publishing.

Arnett, J. J., Žukauskienė, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18–29 years: Implications for mental health. The Lancet Psychiatry, 1(7), 569-576.

Arnett, J. J., & Mitra, D. (2018). Are the features of emerging adulthood developmentally distinctive? A comparison of ages 18–60 in the United States. *Emerging Adulthood, 8*(5), 412–419. https://doi.org/10.1177/2167696818810073.

Arnett, J. J., & Tanner, J. L. (Eds.). (2006). *Emerging adults in America: Coming of age in the 21st century*. American Psychological Association.

Aquilino, W. S. (1997). From adolescent to young adult: A prospective study of parent-child relations during the transition to adulthood. *Journal of Marriage and the Family, 59*, 670–686.

Aquilino, W. S. (2006). Family relationships and support systems in emerging adulthood. In J. J. Arnett & J. L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (p. 193–217). American Psychological Association.

Aquilino, W. S., & Supple, A. J. (2001). Long-term effects of parenting practices during adolescence on well-being outcomes in young adulthood. *Journal of Family Issues, 22*(3), 289–308.

Asendorpf, J. B., & Wilpers, S. (1998). Personality effects on social relationships. *Journal of Personality and Social Psychology, 74*(6), 1531–1544.

Atkinson D. & Lowe S. (1995) The role of ethnicity, cultural knowledge and conventional techniques in counselling and psychotherapy. In J. Ponterotto, J. Casas, L. Suzuki, & C. Alexander (Eds.), *Handbook of multicultural counselling* (p. 387–414). Sage Publications.

Barber, B. K., & Buehler, C. (1996). Family cohesion and enmeshment: Different constructs, different effects. *Journal of Marriage and the Family, 58*(2), 433–441.

Barry, K. L., & Fleming, M. F. (1990). Family cohesion, expressiveness and conflict in alcoholic families. *British Journal of Addiction, 85*(1), 81–87.

Barry, C. M., Madsen, S. D., Nelson, L. J., Carroll, J. S., & Badger, S. (2009). Friendship and romantic relationship qualities in emerging adulthood: Differential associations with identity development and achieved adulthood criteria. *Journal of Adult Development, 16*(4), 209–222.

Barry, C., & Madsen, S. (2010). Friends and friendships in emerging adulthood. *The Changing Spirituality of Emerging Adults.* https://faithformationlearningexchange.net/uploads/5/2/4/6/5246709/friends__friendships_in_emerging_adulthood_-_barry.pdf.

Barry, C. M., Madsen, S. D., & DeGrace, A. (2016). Growing up with a little help from their friends in emerging adulthood. In J. J. Arnett (Ed.), *The Oxford handbook of emerging adulthood* (p. 215–229). Oxford University Press.

Baum, S., Little, K., & Payea, K. (2011). Trends in community college education: Enrollment, prices, student aid, and debt levels. Trends in Higher Education Series. https://www.cgsnet.org/ckfinder/userfiles/files/trends-2011-community-colleges-ed-enrollment-debt-brief.pdf.

Beavers, W. R., Lewis, J. M., Gossett, J. T., & Phillips, V. A. (1975). Crucial variables in healthy family systems. *Dallas Medical Journal, 61*, 313–317.

Beck, A. T., Steer, R. A., & Carbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*(1), 77–100. https://doi.org/10.1016/0272-7358(88)90050-5.

Benson, P. L., Scales, P. C., Hawkins, J. D., Oesterle, S., & Hill, K. G. (2004). Executive summary: successful young adult development. Bill Gates Foundation. https://docs.gatesfoundation.org/documents/successfuldevelopment.pdf.

Bernard, A. (2013). Unemployment dynamics among Canada's youth. Economic Insights. Statistics Canada Catalogue Number 11 626 X-No. 024. https://www150.statcan.gc.ca/n1/pub/11-626-x/11-626-x2013024-eng.htm.

Bertalanffy, L. V. (1968). General systems theory as integrating factor in contemporary science. *Akten des XIV. Internationalen Kongresses für Philosophie, 2*, 335–340.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, research and clinical perspectives.* American Psychological Association Press.

Bloom, B. L. (1985). A factor analysis of self-report measures of family functioning. *Family Process, 24*, 225–239.

Bonnie, R. J., Stroud, C. E., & Breiner, H. E. (2014). *Investing in the health and well-being of young adults*. National Academies Press.

Booth, A., Crouter, A.C., & Shanahan, M.J. (1999). *Transitions to adulthood in changing economy: No work, no family, no future?* Praeger.

Bowen, M. (1966). The use of family theory in clinical practice. *Comprehensive Psychiatry, 7*(5), 345–374.

Bowen, M. (1974). Alcoholism as viewed through family systems theory and family psychotherapy. *Annals of the New York Academy of Sciences, 233*(1), 115–122.

Bowen, M. (1978). *Family treatment in clinical practice.* Jason Aronson, Inc.

Bradford Brown, B., Larson, R. W., & Saraswathi, T. S. (2002). *The world's youth: Adolescence in eight regions of the globe.* Cambridge University Press.

Bradford, A. B., Burningham, K. L., Sandberg, J. G., & Johnson, L. N. (2017). The association between the parent–child relationship and symptoms of anxiety and depression: The roles of attachment and perceived spouse attachment behaviors. Journal of marital and family therapy, 43(2), 291-307.

Bregman, O. C., & White, C. M. (2011). *Bringing systems thinking to life: Expanding the horizons for Bowen family systems theory*. Routledge.

Breton, J. J., Labelle, R., Berthiaume, C., Royer, C., St-Georges, M., Ricard, D., ... & Guilé, J. M. (2015). Protective factors against depression and suicidal behaviour in adolescence. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 60(2 Suppl 1), S5.

Brown, J. (1999). Bowen family systems theory and practice: Illustration and critique. *Australian and New Zealand Journal of Family Therapy, 20*(2), 94–103.

Burt, C. E., Cohen, L. H., & Bjorck, J. P. (1988). Perceived family environment as a moderator of young adolescents' life stress adjustment. *American Journal of Community Psychology, 16*(1), 101–122.

Bynner, J. (2005). Rethinking the youth phase of the life-course: The case for emerging adulthood? *Journal of Youth Studies, 8*(4), 367–384.

Campos, B., Ullman, J. B., Aguilera, A., & Schetter, C. D. (2014). Familism and psychological health: The intervening role of closeness and social support. *Cultural Diversity and Ethnic Minority Psychology, 20*, 191–201.

Carbery, J., & Buhrmester, D. (1998). Friendship and need fulfillment during three phases of young adulthood. *Journal of Social and Personal Relationships, 15,* 393–409.

Carter, B., & McGoldrick, M. (1999). *The expanded family life cycle* (3rd ed.). Allyn & Bacon.

Cassidy, T., & Wright, L. (2008). Graduate employment status and health: A longitudinal analysis of the transition from student. *Social Psychology of Education, 11,* 181–191. https://doi.org/10.1007/s11218-007-9043-x.

Ciarrochi J., Wilson C., Deane F. & Rickwood D. (2003) Do difficulties with emotions inhibit help-seeking in adolescence? The role of age and emotional competence in predicting help-seeking intentions. *Counselling Psychology Quarterly 16*(2), 103–120.

Cohen, P., Kasen, S., Chen, H., Hartmark, C., & Gordon, K. (2003). Variations in patterns of developmental transitions in the emerging adulthood period. *Developmental Psychology, 39*, 657–669.

Coie, J.D., Watt, N.F., West, S.G., Hawkins, J.D., Asarnow, J.R., Markman, H.J., Ramey, S.L., Shure, M.B., Long, B., 1993. The science of prevention—a conceptual-framework and some directions for a national research-program. Am. Psychol. 48, 1013–1022.

Collins, W. A., & Laursen, B. (2004). Parent-adolescent relationships and influences. *Handbook of Adolescent Psychology, 2,* 331–362.

Collins M. & Mowbray C. (2005) Higher education and psychiatric disabilities: national survey of campus disability services. *American Journal of Psychiatry, 75*, 61–67.

Collins, A., & van Dulmen, M. (2006). Friendships and romance in emerging adulthood: Assessing distinctiveness in close relationships. In J. J. Arnett & J. L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (p. 219–234). American Psychological Association.

Collins, W. A., & Madsen, S. D. (2006). Personal relationships in adolescence and early adulthood. In A. L. Vangelisti & D. Perlman (Eds.), *Cambridge handbook of personal relationships* (p. 191–209). Cambridge University Press.

Colman, I., Zeng, Y., McMartin, S. E., Naicker, K., Ataullahjan, A., Weeks, M., ... & Galambos, N. L. (2014). Protective factors against depression during the transition from adolescence to adulthood: findings from a national Canadian cohort. Preventive medicine, 65, 28-32.

Constantine M. & Arorash T. (2001) Universal-diverse orientation and general expectations about counselling: their relation to college students' multicultural counselling expectations. *Journal of College Student Development, 42*, 535–544.

Creamer, E. G., & Laughlin, A. (2005). Self-authorship and women's career decision making. *Journal of College Student Development, 46,* 13–27. https://doi.org/10.1353/csd.2005.0002.

Creed, P. A. (1999). Predisposing factors and consequences of occupational status for long-term unemployed youth: A longitudinal examination. *Journal of Adolescence, 22*, 81–93. https://doi.org/10.1006/jado.1998.0202.

Creed, P. A., & Moore, K. (2006). Social support, social undermining, and coping in underemployed and unemployed persons. *Journal of Applied Social Psychology, 36,* 321–339. https://doi.org/10.1006/jado.1998.0202.

Crespo, C., Kielpikowski, M., Pryor, J., & Jose, P. E. (2011). Family rituals in New Zealand families: Links to family cohesion and adolescents' well-being. *Journal of Family Psychology, 25*(2), 184–193.

Crouter, A. C., & Booth, A. (2006). *Romance and sex in adolescence and emerging adulthood: Risk and opportunities*. Lawrence Erlbaum.

Dingfelder, H. E., Jaffee, S. R., & Mandell, D. S. (2010). The impact of social support on depressive symptoms among adolescents in the child welfare system: A propensity score analysis. *Children and Youth Services Review, 32*(10), 1255–1261.

Domene, J. F., & Arim, R. G. (2016). Associations between depression, employment and relationship status during the transition into the workforce: A gendered phenomenon? *Canadian Journal of Counselling and Psychotherapy, 50*, 35–50.

Domene, J. F., Arim, R. G., & Law, D. M. (2017). Change in depression symptoms through emerging adulthood: disentangling the roles of different employment characteristics. *Emerging Adulthood, 5*(6), 406–416.

Duineveld, J. J., Parker, P. D., Ryan, R. M., Ciarrochi, J., & Salmela-Aro, K. (2017). The link between perceived maternal and paternal autonomy support and adolescent well-being across three major educational transitions. *Developmental Psychology, 53*(10), 1978–1994.

Eccles, J. S., & Gootman, J. A. (Eds.) (2002). Features of positive developmental settings. In *Community programs to promote youth development* (p. 86–118). The National Academies Press.

Elieson, M. V., & Rubin, L. J. (2001). Differentiation of self and major depressive disorders: A test of bowen theory among clinical, traditional, and internet groups. *Family Therapy, 28*(3), 125–142.

Fanti, K. A., Henrich, C. C., Brookmeyer, K. A., & Kuperminc, G. P. (2008). Toward a transactional model of parent-adolescent relationship quality and adolescent psychological adjustment. *The Journal of Early Adolescence, 28*(2), 252–276.

Frye, A. A., & Liem, J. H. (2011). Diverse patterns in the development of depressive symptoms among emerging adults. *Journal of Adolescent Research, 26*(5), 570–590. https://doi.org/10.1177/0743558411402336.

Furman, W., & Buhrmester, D. (1992). Age and sex differences in perceptions of networks of personal relationships. *Child Development, 63*(1), 103–115.

Galambos, N. L., Leadbeater, B. J., & Barker, E. T. (2004). Gender differences in and risk factors for depression in adolescence: A 4-year longitudinal study. *International Journal of Behavioral Development, 28*, 16–25.

Galambos, N. L., Barker, E. T., & Krahn, H. J. (2006). Depression, self-esteem, and anger in emerging adulthood: Seven-year trajectories. *Developmental Psychology, 42*, 350–365. https://doi.org/10.1037/0012-1649.42.2.350.

García-Mendoza, M. D. C., Parra, Á., Sánchez-Queija, I., & Arranz Freijo, E. B. (2020). Emotional autonomy and adjustment among emerging adults: The moderating role of family relationships. *Scandinavian Journal of Psychology, 61*(3), 380–387.

Gavazzi, S. M., Anderson, S. A., & Sabatelli, R. M. (1993). Family differentiation, peer differentiation, and adolescent adjustment in a clinical sample. *Journal of Adolescent Research, 8*, 205–225.

Gavazzi, S. M., Goettler, D. E., Solomon, S. P., & McKenry, P. C. (1994). The impact of family and peer differentiation levels on adolescent psychosocial development and problematic behaviors. *Contemporary Family Therapy, 16*(5), 431–448. https://doi.org/10.1007/BF02197903.

Ge, X., Natsuaki, M. N., Neiderhiser, J. M., & Reiss, D. (2009). The longitudinal effects of stressful life events on adolescent depression are buffered by parent–child closeness. *Development and Psychopathology, 21*(2), 621–635.

Gehart, G. (2016). *Theory and treatment planning in family therapy: A competency-based approach*. Cengage Learning.

Green, G. J., Hamilton, N., & Rolling, M. (1986). Differentiation of self and psychiatric diagnosis: An empirical study. *Family Therapy, 23*(2), 187–194.

Hair, E. C., Moore, K. A., Garrett, S. B., Ling, T., & Cleveland, K. (2008). The continued importance of quality parent–adolescent relationships during late adolescence. *Journal of Research on Adolescence, 18*(1), 187–200.

Harris, T. L., & Molock, S. D. (2000). Cultural orientation, family cohesion, and family support in suicide ideation and depression among African American college students. *Suicide and Life-Threatening Behavior, 30*(4), 341–353.

Hartup, W. W., & Stevens, N. (1999). Friendships and adaptation across the life span. *Current Directions in Psychological Science, 8*(3), 76–79.

Heiligenstein E. & Guenther G. (1996) Depression and academic impairment in college students. *Journal of American College Health, 45*(2), 59–64.

Holdsworth, C., Morgan, D. (2005). *Transitions in context. Leaving home, independence and adulthood.* Open University Press.

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine, 7*(7), Article e1000316.

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science, 10*(2), 227-237.

Horowitz, A. D., & Bromnick, R. D. (2007). "Contestable adulthood" variability and disparity in markers for negotiating the transition to adulthood. *Youth & Society, 39*(2), 209–231.

Hoyle, R., Kernis, M. H., Leary, M. R., & Baldwin, M. W. (2019). *Selfhood: Identity, esteem, regulation*. Routledge.

Hurst, N. C, Sawatzky, D., & Pare, D. P. (1996). Families with multiple problems through a Bowenian lens. *Child Welfare, 75*(6), 693–708.

Hussar, W. J., & Bailey, T. M. (2011). *Projections of education statistics to 2020* (39th edition). NCES 2011-026. National Center for Education Statistics.

Hutchison, E. D. (2018). *Dimensions of human behavior: The changing life course*. Sage Publications.

Jenkins, S. R., Belanger, A., Connally, M. L., Boals, A., & Durón, K. M. (2013). First-generation undergraduate students' social support, depression, and life satisfaction. Journal of College Counseling, 16(2), 129-142.

Johnson, V. K., Gans, S. E., Kerr, S., & LaValle, W. (2010). Managing the transition to college: Family functioning, emotion coping, and adjustment in emerging adulthood. *Journal of College Student Development, 51*(6), 607–621.

Kaman, A., Otto, C., Klasen, F., Westenhöfer Joachim, Reiss, F., Hölling Heike, & Ravens-Sieberer, U. (2020). Risk and resource factors for depressive symptoms during adolescence and emerging adulthood - a 5-year follow-up using population-based data of the bella study. Journal of Affective Disorders. https://doi.org/10.1016/j.jad.2020.11.036

Kaplan, H. B., Robbins, C., & Martin, S. S. (1983). Antecedents of psychological distress in young adults: Self-rejection, deprivation of social support, and life events. *Journal of Health and Social Behavior, 24*(3), 230–244.

Kerr, M. E., & Bowen, M. (1988). *Family evaluation.* Norton.

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T. B. (2007). Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c.

Klasen, F., Otto, C., Kriston, L., Patalay, P., Schlack, R., Ravens-Sieberer, U., & Bella Study Group. (2015). Risk and protective factors for the development of depressive symptoms in children and adolescents: results of the longitudinal BELLA study. European child & adolescent psychiatry, 24(6), 695-703.

Klever, P. (2004). The multigenerational transmission of nuclear family processes and symptoms. *The American Journal of Family Therapy, 32*(4), 337–351.

Knudson-Martin, C. (1996). Differentiation and self-development in the relationship context. *The Family Journal: Counseling and Therapy for Couples and Families, 4,* 188–198.

Konner, M. (2019). Emerging adulthood, a pre-adult life-history stage. *Frontiers in Endocrinology, 10*, 918.

Kopala-Sibley, D. C., Zuroff, D. C., Hermanto, N., & Joyal-Desmarais, K. (2016). The development of self-definition and relatedness in emerging adulthood and their role in the development of depressive symptoms. *International Journal of Behavioral Development*, *40*(4), 302–312.

Kuwabara, S. A., Van Voorhees, B. W., Gollan, J. K., & Alexander, G. C. (2007). A qualitative exploration of depression in emerging adulthood: disorder, development, and social context. *General Hospital Psychiatry*, *29*(4), 317–324.

Lamis, D. A., & Lester, D. (2013). Gender differences in risk and protective factors for suicidal ideation among college students. *Journal of College Student Psychotherapy*, *27*(1), 62–77.

Lane, J. A. (2015). Counseling emerging adults in transition: Practical applications of attachment and social support research. *The Professional Counselor*, *5*(1), 30–42.

Lane, J. A., & Fink, R. S. (2015). Attachment, social support satisfaction, and well-being during life transition in emerging adulthood. *The Counseling Psychologist*, *43*(7), 1034–1058.

Lapierre, S., & Poulin François. (2019). Friendship instability and depressive symptoms in emerging adulthood. *Journal of American College Health,* advance online publication. https://doi.org/10.1080/07448481.2020.1801693.

Lee, C. Y. S., & Dik, B. J. (2016). Associations among stress, gender, sources of social support, and health in emerging adults. *Stress and Health*, *33*(4), 378–388.

Li, H., Ji, Y., & Chen, T. (2014). The roles of different sources of social support on emotional well-being among Chinese elderly. *PloS One*, *9*(3), Article e90051.

Lindell, A. K., & Campione-Barr, N. (2016). Continuity and change in the family system across the transition from adolescence to emerging adulthood. *Marriage & Family Review*, *53*(4), 388–416. https://doi.org/10.1080/01494929.2016.1184212.

Lisznyai, S., Vida, K., Németh, M., & Benczúr, Z. (2014). Risk factors for depression in the emerging adulthood. *The European Journal of Counselling Psychology*, *3*(1), 54–68. https://doi.org/10.5964/ejcop.v3i1.22.

Macmillan, R., & Copher, R. (2005). Families in the life course: Interdependency of roles, role configurations, and pathways. *Journal of Marriage and Family, 67*, 858–879.

Mahmoud, J., Staten, R., Lennie, T., & Hall, L. (2015). The relationships of coping, negative thinking, life satisfaction, social support, and selected demographics with anxiety of young adult college students. *Journal of Child and Adolescent Psychiatric Nursing, 28*(2), 97–108. https://doi.org/10.1111/jcap.12109.

Masten, A.S., Cutuli, J.J., Herbers, J.E., Reed, M.G. (2009). Resilience in development *Oxford handbook of positive psychology*, Oxford University Press, USA, New York

Marcotte, D. (Ed.). (2013). *Depression in adolescents: State of knowledge, family, school and intervention strategies.* PUQ.

McFarland, J., Hussar, B., Zhang, J., Wang, X., Wang, K., Hein, S., Diliberti, M., Forrest Cataldi, E., Bullock Mann, F., & Barmer, A. (2019). The condition of education 2019 (NCES 2019-144). National Center for Education Statistics. https://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2019144.

McGee, R. E., & Thompson, N. J. (2010). Unemployment and depression among emerging adults in 12 states, behavioral risk factor surveillance system, 2010. *Preventing Chronic Disease*, *12*, Article 140451.

Miething, A., Almquist, Y. B., Östberg, V., Rostila, M., Edling, C., & Rydgren, J. (2016). Friendship networks and psychological well-being from late adolescence to young adulthood: a gender-specific structural equation modeling approach. *BMC Psychology*, *4*(1), Article 34.

Minuchin, S., Baker, L., Rosman, B. L., Liebman, R., Milman, L., & Todd, T. C. (1975). A conceptual model of psychosomatic illness in children: Family organization and family therapy. *Archives of General Psychiatry, 32*(8), 1031–1038.

Minuchin, P. (1985). Families and individual development: Provocations from the field of family therapy. *Child Development, 56,* 289–302. https://doi.org/10.2307/1129720.

Moksnes, U. K., & Lazarewicz, M. (2019). The association between stress, resilience, and emotional symptoms in Norwegian adolescents from 13 to 18 years old. Journal of health psychology, 24(8), 1093-1102.

Monahan, K. C., Oesterle, S., Rhew, I., & Hawkins, J. D. (2014). The relation between risk and protective factors for problem behaviors and depressive symptoms, antisocial behavior, and alcohol use in adolescence. Journal of Community Psychology, 42(5), 621-638.

Mondi, C. F., Reynolds, A. J., & Ou, S. R. (2017). Predictors of depressive symptoms in emerging adulthood in a low-income urban cohort. *Journal of Applied Developmental Psychology*, *50*, 45–59.

Murphy, K. A., Blustein, D. L., Bohlig, A. J., & Platt, M. G. (2010). The college-to-career transition: An exploration of emerging adulthood. *Journal of Counseling & Development, 88*, 174–181. https://doi.org/10.1002/j.1556-6678.2010.tb00006.x.

National Institute of Mental Health (2019). *Major depression.* Retrieved June 2020 from https://www.nimh.nih.gov/health/statistics/major-depression.shtml

National Survey of Student Engagement. (2007). *Experiences that matter: Enhancing student learning and success, annual report 2007.* National Survey of Student Engagement.

Nichols, M. P. (2013). *Family therapy: Concepts and methods* (10th edition). Pearson.

Noble, J. T., Cover, J., & Yanagishita, M. (1996). *The world's youth.* Population Reference Bureau

Oesterle, S., David Hawkins, J., Hill, K. G., & Bailey, J. A. (2010). Men's and women's pathways to adulthood and their adolescent precursors. *Journal of Marriage and Family, 72*(5), 1436–1453.

Olson, D. H., Russell, C. S., & Sprenkle, D. H. (1983). Circumplex model of marital and family systems: VI. Theoretical update. *Family Process, 22,* 69–83.

Oxman, T. E., Berkman, L. F., Kasl, S., Freeman Jr, D. H., & Barrett, J. (1992). Social support and depressive symptoms in the elderly. *American Journal of Epidemiology, 135*(4), 356–368.

Palosaari, U., Aro, H., & Laippala, P. (1996). Parental divorce and depression in young adulthood: Adolescents' closeness to parents and self-esteem as mediating factor. *Acta Psychiatrica Scandinavica, 93*(1), 20–26.

Parra, Á., Oliva, A., & Sánchez-Queija, I. (2013). Development of emotional autonomy from adolescence to young adulthood in Spain. *Journal of Adolescence, 38,* 57–67. https://doi.org/10.1016/j.adolescence.2014.11.003.

Parra, A., Oliva, A., & Reina, M. D. C. (2015). Family relationships from adolescence to emerging adulthood: a longitudinal study. *Journal of Family Issues, 36*(14), 2002–2020. https://doi.org/10.1177/0192513X13507570.

Paus, T., Keshavan, M., & Giedd, J. N. (2008). Why do many psychiatric disorders emerge during adolescence? *Nature Reviews Neuroscience, 9*(12), 947–957. https://doi.org/10.1038/nrn2513.

Pettit, J. W., Roberts, R. E., Lewinsohn, P. M., Seeley, J. R., & Yaroslavsky, I. (2011). Developmental relations between perceived social support and depressive symptoms through emerging adulthood: Blood is thicker than water. *Journal of Family Psychology, 25*, 127–136.

Ponappa, S., Bartle-Haring, S., Holowacz, E., & Ferriby, M. (2016). The family system and depressive symptoms during the college years: Triangulation, parental differential treatment, and sibling warmth as predictors. *Journal of Marital and Family Therapy, 43*(1), 145–158. https://doi.org/10.1111/jmft.12175.

Powers, S. L., Hauser, S. T., & Kilner, L. A. (1989). Adolescent mental health. *American Psychologist, 44,* 200–208. https://doi.org/10.1037/0003-066X.44.2.200.

Procidano, M. E., & Heller, K. (1983). Measures of perceived social support from friends and from family: Three validation studies. *American Journal of Community Psychology, 11*(1), 1–24.

Raffaelli, M., Andrade, F. C., Wiley, A. R., Sanchez-Armass, O., Edwards, L. L., & Aradillas-Garcia, C. (2013). Stress, social support, and depression: A test of the stress-buffering hypothesis in a Mexican sample. *Journal of Research on Adolescence, 23*(2), 283–289.

Rask, K., Åstedt-Kurki, P., Paavilainen, E., & Laippala, P. (2003). Adolescent subjective well-being and family dynamics. *Scandinavian Journal of Caring Sciences, 17*(2), 129–138.

Rauer, A. J., & Volling, B. L. (2007). Differential parenting and sibling jealousy: Developmental correlates of young adults' romantic relationships. *Personal Relationships, 14,* 495–511.

Raya Trenas, A., Aguilar Yamuza, B., Herruzo Cabrera, J., & Pino Osuna, M. J. (2020). Paternal and maternal variables related to depression in childhood. International journal of environmental research and public health, 17(1), 275.

Reed-Fitzke, K. (2019). The role of self-concepts in emerging adult depression: A systematic research synthesis. *Journal of Adult Development*, *27*(1), 36–48.

Reifman, A., Arnett, J. J., & Colwell, M. J. (2007). Emerging adulthood: Theory, assessment and application. *Journal of Youth Development*, *2*(1), 37–48.

Reinherz, H. Z., Paradis, A. D., Giaconia, R. M., Stashwick, C. K., & Fitzmaurice, G. (2003). Childhood and adolescent predictors of major depression in the transition to adulthood. *American Journal of Psychiatry*, *160*(12), 2141–2147.

Rivera, F. I. (2007). Contextualizing the experience of young Latino adults: Acculturation, social support and depression. *Journal of Immigrant and Minority Health*, *9*, 237–244.

Roberts, R. E., & Bengtson, V. L. (1993). Relationships with parents, self-esteem, and psychological well-being in young adulthood. *Social Psychology Quarterly*, 56(4), 263–277.

Rohde, P., Lewinsohn, P. M., Klein, D. N., Seeley, J. R., & Gau, J. M. (2013). Key characteristics of major depressive disorder occurring in childhood, adolescence, emerging adulthood, and adulthood. *Clinical Psychological Science, 1*(1), 41–53.

Rossi, A. S., & Rossi, P. P. H. (1990). *Of human bonding: Parent child relations across the life course.* Transaction Publishers.

Sabatelli, R. M., & Anderson, S. A. (1991). Family system dynamics, peer relationships, and adolescents' psychological adjustment. *Family Relations, 40*, 363–369.

Santini, Z. I., Koyanagi, A., Tyrovolas, S., Mason, C., & Haro, J. M. (2015). The association between social relationships and depression: A systematic review. *Journal of Affective Disorders*, *175*, 53–65. https://doi.org/10.1016/j.jad.2014.12.049.

Saraswathi, T. S., & Larson, R. W. (2002). An Agenda for Social Policy. The world's youth: Adolescence in eight regions of the globe, 344.

Scales, P. C., Benson, P. L., Oesterle, S., Hill, K. G., Hawkins, J. D., & Pashak, T. J. (2016). The dimensions of successful young adult development: A conceptual and measurement framework. *Applied Developmental Science*, *20*(3), 150–174.

Schulenberg, J. E., & Zarrett, N. R. (2006). Mental Health During Emerging Adulthood: Continuity and Discontinuity in Courses, Causes, and Functions.

Schuster, T. L., Kessler, R. C., & Aseltine, R. H. J. (1990). Supportive interactions, negative interactions, and depressed mood. *American Journal of Community Psychology*, *18*(3), 423–438.

Settersten, R., & Ray, B. (2010). What's going on with young people today? The long and twisting path to adulthood. *The Future of Children*, *20*(1), 19–41.

Shortt, A.L., Spence, S.H., 2006. Risk and protective factors for depression in youth. Behav. Change 23, 1–30.

Simmons, A. N. (2008). A reliable sounding board: Parent involvement in students' academic and career decision-making. *National Academic Advising Association (NACADA), 28*, 33–43.

Skinner. H.A., Steinhauer, P.D., & Santa-Barbara, J. (1983). The family assessment measure. *Canadian Journal of Community Mental Health, 2*, 91–105.

Skowron, E. A., Wester, S. R., & Azen, R. (2004). Differentiation of self-mediates college stress and adjustment. *Journal of Counseling & Development, 82*(1), 69–78. https://doi.org/10.1002/j.1556-6678.2004.tb00287.x

Spencer, S. M., & Patrick, J. H. (2009). Social support and personal mastery as protective resources during emerging adulthood. Journal of Adult Development, 16(4), 191-198.

Steger, M. F., & Kashdan, T. B. (2009). Depression and Everyday Social Activity, Belonging, and Well-Being. Journal of counseling psychology, 56(2), 289–300. https://doi.org/10.1037/a0015416

Sze, T. M., Lin, S. H., Hsieh, P. J., & Chen, I. J. (2013). Sex differences in the development of perceived family cohesion and depressive symptoms in Taiwanese adolescents. Psychological Reports, 113(1), 54-72.

Tam, C. L., & Lim, S. G. (2009). Perceived social support, coping capability and gender differences among young adults. Sunway Academic Journal, 6, 75-88.

Tanner, J. L. (2006). Recentering during emerging adulthood: A critical turning point in life span human development. In J. J. Arnett & J. L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (p. 21–55). American Psychological Association.

Taylor, Z. E., Doane, L. D., & Eisenberg, N. (2014). Transitioning from high school to college: Relations of social support, ego-resiliency, and maladjustment during emerging adulthood. *Emerging Adulthood*, *2*(2), 105–115.

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, *52*(2), 145–161.

Thornton, A., Orbuch, T. L., & Axinn, W. G. (1995). Parent–child relationships during the transition to adulthood. *Journal of Family Issues*, *16*, 538–564. https://doi.org/10.1177/019251395016005003.

Tinto, V. (2012). *Completing college: Rethinking institutional action.* University of Chicago Press.

Townsend, K. C., & McWhirter, B. T. (2011). Connectedness: A review of the literature with implications for counseling, assessment, and research. Journal of Counseling & Development, 83(2), 191-201.

Tubman, J. G., & Lerner, R. M. (1994). Continuity and discontinuity in the affective experiences of parents and children: Evidence from the New York Longitudinal Study. *American Journal of Orthopsychiatry, 64*, 112–125. https://doi.org/10.1037/h0079488.

Turner A., Hammond C., Gilchrist M. & Barlow J. (2007) Coventry university students' experience of mental health problems. *Counselling Psychology Quarterly*, *20*(3), 247–252.

Umberson, D. (1992). Relationships between adult-children and their parents. Psychological consequences for both generations. *Journal of Marriage and the Family, 54*, 664–674.

Vieno, A., Nation, M., Pastore, M., & Santinello, M. (2009). Parenting and antisocial behavior: A model of the relationship between adolescent self-disclosure, parental closeness, parental control, and adolescent antisocial behavior. *Developmental Psychology, 45*(6), 1509–1519.

Villatte, A., Marcotte, D., & Potvin, A. (2017). Correlates of depression in first-year college students. *Canadian Journal of Higher Education, 47*(1), 114–136.

Voncina, M. M., Kosutic, Z., Pesic, D., Todorovic, D., Peulic, A., Lazarevic, M., ... & Gotlib, D. (2018). Family and Personality Predictors of Clinical Depression and Anxiety in Emerging Adults: Common, Distinctive, or a Vulnerability Continuum?. The Journal of Nervous and Mental Disease, 206(7), 537-543.

Walen, H. R., & Lachman, M. E. (2000). Social support and strain from partner, family, and friends: Costs and benefits for men and women in adulthood. *Journal of Social and Personal Relationships, 17*(1), 5–30.

Watson, W. H. (2012). Family systems. In V. Ramachandran (Ed.), *Encyclopedia of human behavior* (2nd edition) (p. 184–193). Academic Press.

Weymouth, B. B., Buehler, C., Zhou, N., & Henson, R. A. (2016). A meta-analysis of parent-adolescent conflict: disagreement, hostility and youth maladjustment. *Journal of Family Theory & Review, 8*(1), 95–112.

White, J. M., Klein, D. M., & Martin, T. F. (2015). *Family theories: An introduction* (4th edition). Sage Publications.

Whitbeck, L., Hoty, D., Simons, R., Conger, R., Elder, G., Lorenz, F., & Huck, S. (1992). Intergenerational continuity of parental rejection and depressed affect. *Journal of Personality and Social Psychology, 63*, 1036–1045.

Williams, K. L., & Galliher, R. V. (2006). Predicting depression and self–esteem from social connectedness, support, and competence. Journal of Social and Clinical Psychology, 25(8), 855-874.

Wille, N., & Ravens-Sieberer, U. (2010). How to assess resilience: Reflections on a measurement model. In Health assets in a global context (pp. 117-143). Springer, New York, NY.

Withers, M. C., McWey, L. M., & Lucier-Greer, M. (2016). Parent–adolescent relationship factors and adolescent outcomes among high-risk families. *Family Relations, 65*(5), 661–672.

Wodka, E. L., & Barakat, L. P. (2007). An exploratory study of the relationship of family support and coping with adjustment: Implications for college students with a chronic illness. *Journal of Adolescence, 30*(3), 365–376. https://doi.org/10.1016/j.adolescence.2006.04.002.

World Health Organization. (2017). Depression and other common mental disorders: Global health estimates (Reference Number WHO/MSD/MER/2017.2). World Health Organization.

Wrzus, C., Wagner, J., & Neyer, F. J. (2012). The interdependence of horizontal family relationships and friendships relates to higher well-being. *Personal Relationships, 19*(3), 465–482.

Zarrett, N., & Eccles, J. (2006). The passage to adulthood: Challenges of late adolescence. *New Directions for Youth Development, 2006*(111), 13–28.